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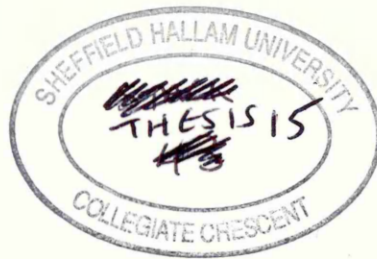
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بِسْمِ اللَّهِ الرَّحْمَنِ الرَّحِيمِ

**"BRIDGING" THERAPY IN HOSPITAL -
AND COMMUNITY-BASED PSYCHIATRIC NURSING CARE:
A COMPARATIVE STUDY**

by

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VOLUME I

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May 1988

"BRIDGING" THERAPY IN HOSPITAL- AND COMMUNITY-BASED

PSYCHIATRIC NURSING CARE: A COMPARATIVE STUDY

NELLY AHMED MAHGOUB RGN BSc(Hons) MSc

ABSTRACT

This study presents a detailed account of Bridging Therapy - an innovative intervention aimed at providing relatively comprehensive psychiatric nursing care for mentally ill patients. Starting at hospitalisation, Bridging Therapy continues as planned nursing care based on detailed assessment of the patient's short- and longer-term needs both before and after discharge to the community, delivered where possible by the same nurse, or by members of the same nursing team. Bridging Therapy thus presents a remedial model for current fragmented patterns of nursing care, based on an eclectic approach to psychotherapy and nursing process known as the "flexible integrative approach" (FIA).

The study recognises problems caused by lack of patient outcome measures in psychiatric nursing; and approaches this by developing an appropriate assessment instrument, the Behaviour Adjustment Inventory (BAI), which is initially tested in concurrent use with a well-validated psychometric instrument (the GHQ); with a second well-validated instrument (the EPI) acting as an initial screening device. The BAI assesses patients' initial status on admission and subsequent responses to Bridging Therapy on a five-point scale, used in conjunction with detailed clinical criteria of behaviour and attitude change.

Clinical evaluation of patients in the contrasted contexts of Sheffield and Cairo is described. In each context, experimental (Bridging Therapy) and control (non-Bridging Therapy) groups are studied (Sheffield total N = 22; Cairo total N = 18). Assessment of initial condition was carried out on admission to hospital; recovery status on discharge, and at the close of therapeutic follow-up in the community. Results indicate similar levels of recovery for Sheffield and Cairo groups, with a more pronounced tendency to recovery in the experimental (Bridging Therapy) groups; however, this difference does not reach statistical significance.

Psychometric findings are augmented by qualitative descriptions of the implementation process. Two detailed nursing studies from each context are presented. The investigation highlights the complexity of the research problem, including important transcultural considerations; identifies multifactorial issues governing patient care; and supports further research into Bridging Therapy as a potential remedy for current gaps in psychiatric nursing care, both in Britain and Egypt. Relevant materials concerning historical/structural aspects of mental health care and varieties of psychotherapy (Chapters 1 through 3) are included because of their contextual importance both to British and Egyptian workers.

PREFACE

As an Egyptian, the researcher recognised the need for improvements in the Egyptian psychiatric nursing service; especially in opening-up the of community psychiatric nursing care, which is currently non-existent in Egypt. Initially, she naively assumed that Britain would be able to provide a developed model of community psychiatric nursing care which would transfer to Egypt.

This assumption changed when the researcher was confronted with the reality of the many problems encountered by newly-discharged patients and their carers in Britain. In the first weeks of the preparatory phase, it became clear that the British system of community psychiatric nursing care has developed in an ad hoc manner; and that consequently it has numerous gaps and varies greatly across the country.

Conducting appropriate research to produce a useful model of community psychiatric nursing that would transfer to Egypt became a strong personal commitment. Initial research plans, which involved systematic appraisal of a supposedly well developed "British" community psychiatric nursing model, followed by empirical testing of this model of Egypt, had to be changed twice during the course of study.

First, a decision was made that, due to lack of a model for comprehensive community psychiatric nursing in Britain, the researcher should attempt to initiate and test a model that would be both theoretically and empirically sound. Therefore, bridging therapy was developed to suggest some solutions to one of the most pressing problems - that of bridging the gap between hospital- and community-based psychiatric nursing care.

The choice of research problem proved complex due to numerous factors, including lack of suitable assessment instrument for patient outcomes in the field of community psychiatric nursing. Considerably more time than initially anticipated was spent in developing such an instrument. Consequently, data collection in Sheffield was time-consuming, extending over two and a half years, sometimes for ten hours a day, five days a week.

This situation was not encouraging, since it indicated that, in its initial form, bridging therapy was not cost-effective in the British context. However, remarkable improvements had been noted in both groups studied in Sheffield, both in qualitative and quantitative terms. This led to the second decision - ie to test the utility and applicability of bridging therapy in Cairo. Accordingly, the research plan was further revised to become a comparative study within the context of evaluation research.

Positive outcomes of these fundamental changes in the plan of work cannot be denied. However, the associated setbacks resulted in a prolonged study periods seemingly endless frustration with lack of adequate facilities and a further financial ordeal encountered when the money ran out! Nonetheless, it has been worthwhile if, as is hoped, readers of the study enjoy its philosophical stance, its innovative approaches to an old and intractable problem; and the compensatory mechanisms employed to deal with many of the problems encountered.

Acknowledgements

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List of Contents

VOLUME (1)

	<u>Page</u>
Abstract	i
Preface	ii
Acknowledgements	iii
List of Contents	iv
Introduction and Summary	1
 CHAPTER 1: Bridging Therapy in its Cross-Cultural Context	 5
Introduction	6
1.2 The Research Problem	10
1.3 The Proposed Model of 'Bridging Therapy'	12
1.4 The Current Study	13
1.5 Research Aim and Hypotheses	15
1.6 Cross-Cultural Aspects of the Study Context	16
1.6.1 Concept of Culture	16
1.6.2 Socio-cultural Relationship to Mental Illness in Egypt and Associated Cultures	17
1.6.3 Epidemiology of Mental Illness in Egypt and Associated Cultures	20
1.6.4 Psychiatric Nursing in Egypt: Education, Work and Attitudes towards Psychiatric Patients	24
1.6.5 Treatment and Healing Approaches in Egypt and Associated Cultures	32
1.6.6 Research Problems Associated with Cross-cultural Studies	41
1.6.7 Western Style of Mental Health Care	46
 CHAPTER 2 : Community Mental Health Services	 49
2.1 Conceptual Base of Community Psychiatric Care in UK and America	50
2.2 Legislative Aspects of the Development of the Community Mental Health Service	58

	<u>Page</u>
2.2.1 Community Psychiatric Nursing Services in the UK	58
2.2.2 Community Mental Health Care in the USA	61
2.2.3 Community Psychiatric Care in Egypt	62
2.3 Historical Review of Community Mental Health Service Development	62
2.3.1 The UK	62
2.3.2 Egypt	70
2.4 The Community Psychiatric Nursing Role	73
2.4.1 The Ideology of the CPN Role	73
2.4.2 Role Expectations	83
2.4.3 Problems	85
2.4.4 Cost Effectiveness	88
2.4.5 Educational Preparation	91
2.5 A Review of Proposals for Modification of the Service	96
CHAPTER 3: Models of Therapeutic Intervention	108
3.1 Introduction	109
3.2 Three Relevant Psychotherapeutic Approaches	112
3.2.1 Thorne's Eclectic System	112
3.2.2 Reality Therapy	119
3.2.3 Supportive Psychotherapy	122
3.3 The Flexible Integrative Approach (FIA)	125
3.4 Classification of the Main Therapeutic Models	128
3.4.1 Psychoanalytic	128
3.4.2 Humanist-Existential	129
3.4.3 Perceptual-Phenomenological	130
3.4.4 The Rational Approach	132
3.4.5 Behavioural	136
3.4.6 Biological Model	138
3.4.7 Social Model	139
3.4.8 Group Therapy	140
3.5 Practical Implementation and Limitations of the FIA - Psychotherapeutic	145
3.6 Practical Implementation of the FIA - Nursing Process	150
3.7 Conclusions	155
CHAPTER 4: Methodology	157
4.1 Introduction	159

	<u>Page</u>
4.2	Research Design 159
4.2.1	Part One: Theoretical Background of the Study 159
4.2.1.1	Qualitative/Quantitative Techniques 160
4.2.1.2	The Nature of The Study 164
	Quasi-Experimental; Action Research
4.2.1.3	Data Collection Strategies 169
	Observation; In-depth Interview
	Self-Report Questionnaires
4.2.1.4	Sampling 176
4.2.1.5	Limitations of the Proposed Research Design 178
4.2.2	Part Two: The Technical Design of the Study 179
4.2.2.1	Cross-cultural Aspects 181
4.2.2.2	The Two Phases of the Study 201
4.3	Methods of Data Collection 204
4.3.1	Semi-Participant Observation 206
4.3.2	In-Depth Interviews 208
4.3.3	Self-Report Questionnaires 210
4.3.4	Checklists: The Behavioural Adjustment Inventory (BAI) and its Recovery Index (RI) 211
4.3.5	Data Collection Instruments - In Sheffield; In Cairo 212
4.3.6	Development of the Behavioural Adjustment Inventory (BAI) 217
4.3.6.1	Main Purposes of the BAI 217
4.3.6.2	Theoretical Background of the BAI 219
4.3.6.3	Structural Components of the BAI 221
4.3.6.4	Technical Development of the BAI 223
4.3.6.5	Development of the Recovery Index (RI) 225
4.3.6.6	Theoretical Bases of RI Development 226
4.3.6.7	Limitations of the BAI ₁₀₀ and its RI 228
4.3.6.8	Validation Phase and New Version of the BAI 229
4.3.6.9	Testing Validity and Inter-Rater Reliability of BAI ₃₀ in Cairo 233
4.4	Sampling Strategy 235
4.4.1	In Sheffield 235
4.4.2	In Cairo 240
4.5	Implementation of Bridging Therapy 243
4.5.1	In Sheffield 243
4.5.1.1	Bridging Therapy compared with the current conventional provision 248
4.5.2	In Cairo 250
4.6	Methodological Limitations of the Current Study 254

	<u>Page</u>
4.7 Summary	256
CHAPTER 5: Research Findings	258
5.1 Introduction	259
5.2 Description of the Samples	259
5.2.1 The Sheffield Sample	259
5.2.2 The Cairo Sample	262
5.3 The Quantitative Findings	264
5.4 The Qualitative Findings	274
5.4.1 Detailed Case Study No. 1 (Sheffield Field Work)	277
5.4.2 Detailed Case Study No. 2 (Sheffield Field Work)	301
5.4.3 Detailed Case Study No. 3 (Cairo Field Work)	331
5.4.4 Detailed Case Study No. 4 (Cairo Field Work)	355
CHAPTER 6: Discussion	376
6.1 Introduction	377
6.2 Limitations of the Study	379
6.2.1 Practicality of Bridging Therapy	380
6.2.2 Complexity of Design	382
6.2.3 Limited Statistical Significance	385
6.2.4 Use of a New Behavioural Instrument	387
6.2.5 Unobtrusive Measures, Data Redundancy and Observer Time	388
6.2.6 Cross-Cultural Differences	388
6.3 Assessment of Therapeutic Effectiveness of Bridging Therapy	391
6.3.1 Bridging Therapy as Evaluation Research	391
6.3.2 Bridging Therapy in its Cross-Cultural Context	396
6.3.3 Bridging Therapy as a Model for Comprehensive Community Psychiatric Nursing Care	401
6.4 Discussion of Results	405
6.4.1 Discussion of Quantitative Data	405
6.4.1.1 Comparability of BAI ₃₀ with GHQ Scores	406
6.4.1.2 Lack of Statistical Differences between Experimental and Control Groups	408
6.4.1.3 Lack of Statistical Difference between Discharge and Post-Follow-Up Scores	413
6.4.2 Discussion of Qualitative Data	417
6.4.2.1 Patients' Perceptions of Their Problems	417

	<u>Page</u>
6.4.2.2 The Therapeutic Intervention Model	421
6.5 Implications of the Study	431
6.5.1 Clinical Implications	431
6.5.2 Educational Implications	432
6.5.3 Organisational Implications	434
6.5.4 Research Implications	436
6.6 Conclusion	438
References and Bibliography	441

LIST OF TABLES

Table 1.1	Early Nursing Disciplines and Training	25
Table 1.2	Comparison of Traditional and Western Treatment Styles	33
Table 1.3	Hospital and Outpatient Clinics	38
Table 1.4	Total Bedservice and Psychiatrists	39
Table 4.1	Residential Categories in El-Niel Sanatorium	193
Table 4.2	Matching Process in Sheffield Experimental and Control Groups	240
Table 4.3	Matching Process in Cairo Experimental and Control Groups	242
Table 5.1	Sex distribution both in Sheffield and Cairo Samples	259
Table 5.2	British sample distribution - living with family or on own	260
Table 5.3	British sample outcomes in relation to hospitalisation or death	261
Table 5.4	Married/single distribution in the Egyptian sample	262
Table 5.5	GHQ measure of improvement of the Sheffield sample at three intervals	265
Table 5.6	BAI ₃₀ measures of improvement of the Sheffield sample on three occasions	266
Table 5.7	Comparison of improvement gained by both experimental and control groups of the British Sample, as measured by the BAI ₃₀	267

		<u>Page</u>
Table 5.8	GHQ measurement of improvement in the Egyptian sample on three occasions	269
Table 5.9	BAI ₃₀ measurement of improvement for the Egyptian sample on three occasions	270
Table 5.10	Summary of BAI ₃₀ Assessment for Geoffrey Raymonds	298
Table 5.11	Summary of BAI ₃₀ Assessment for Julie Allen	329
Table 5.12	Summary of BAI ₃₀ Assessment for Yassin El-Khaly	350
Table 5.13	Summary of BAI ₃₀ Assessment for Sherifa Adleby	373

LIST OF FIGURES

Figure 5.1	The linear trend of the two groups in Sheffield	268
Figure 5.2	The linear trend of the two groups in Cairo	271
Figure 5.3	GHQ of both groups in Sheffield and Cairo	272
Figure 5.4	BAI ₃₀ of both groups	273

LIST OF ILLUSTRATIONS

Illustration 5.1	Interpretative images: (A) The Blackness of Death	322
Illustration 5.2	Interpretative images: (B) The Sad Face	323
Illustration 5.3	Interpretative images: (C) The Torn Uterus	324
Illustration 5.4	Interpretative images: (D) Anger and Destruction	325

VOLUME (2)	APPENDICES	<u>Page</u>
Appendix 1	Day Hospital Psychiatric Unit, Northern General Hospital	A1
Appendix 2	Eysenck Personality Inventory	A7
Appendix 3	General Health Questionnaire	A11
Appendix 4	BAI - Draft for use with Pilot Samples	A15
Appendix 5	BAI Recovery Index	A21
Appendix 6	Scoring Criteria for BAI	A57
Appendix 7	BAI - General Assessment Sheet	A80
Appendix 8	Membership of BAI Working Group	A81
Appendix 9	BAI - Draft for use with Main Samples	A82
Appendix 10	BAI Draft Manual - Modified Version I	A88
Appendix 11	BAI Draft Manual - Modified Version II	A114
Appendix 12	BAI Assessment Form	A125
Appendix 13	Arabic Version of the GHQ	A133
Appendix 14	Arabic Version of the EPQ	A135
Appendix 15	GHQ Summary Table - Sheffield Sample	A139
Appendix 16	BAI Summary Table - Sheffield Sample 30	A140
Appendix 17	EPI Summary Table - Sheffield Sample	A141
Appendix 18	GHQ Summary Table - Cairo Sample	A142
Appendix 19	BAI Summary Table - Cairo Sample 30	A143
Appendix 20	EPQ Summary Table - Cairo Sample	A144
	<u>Brief Case Studies</u>	
Appendix 21	Ronald Black	A145
Appendix 22	Rahmy Fahad	A154
Appendix 23	Victoria Carr	A162
Appendix 24	Angela Whitehead	A169
Appendix 25	Sadek Abed-El-Hamid	A181
Appendix 26	Nadia El-Gamale	A190
Appendix 27	Abdel El-Fatah	A199

Introduction and Summary

The current study is based on the principle of continuity of care for mentally ill patients by the same nursing personnel who initiate the therapeutic relationship during hospitalisation. It set out to test the effectiveness of this principle by means of a specially-designed model of care termed "bridging therapy". This term refers to bridging the existing gap between hospital-based psychiatric nursing care and community-based psychiatric nursing care which appeared typical of conventional care in Sheffield, where each service worked independently of the other. This system prevented patients maintaining a therapeutic relationship with their nurse keyworker or nurse therapist following discharge from hospital.

The aim was to provide a model of nursing care that would unite hospital and community-based psychiatric nursing care into an integrated system. An additional aim was to transfer this concept to the Egyptian therapeutic field. A main hypothesis assumed that mentally ill patients who receive bridging therapy, either in Sheffield or in Cairo, would improve significantly, and would maintain this improvement till the end of the follow-up period.

The design of this investigation required both quantitative and qualitative approaches. The quantitative approach consisted of a quasi-experimental technique which tested the effectiveness of bridging therapy at two intervals. The qualitative approach consisted of a detailed descriptive analysis of patient outcomes in relation to a number of relevant personal and social factors.

The quasi-experiment took place in two different cultural settings: Britain, a western industrialised developed country; and Egypt, a Middle Eastern developing country. Ward 56 in the Northern General Hospital at Sheffield was the British setting; whilst the Egyptian setting was the El Niel Sanatorium in Cairo. The British setting employed the principles of therapeutic community; whilst the

Egyptian private sanatorium employed a mainly custodial model of care. In Sheffield 22 patients participated and in Cairo 18 patients participated (total N = 40).

The sample for each setting was divided into two equal groups, quasi-experimental and control. The experimental groups received bridging therapy whilst the control groups received conventional nursing care. The EPI was used as a personality screening test for inclusion in experimental and control groups. Assessment of therapeutic outcomes acted as an indicator of the effectiveness of bridging therapy. Two instruments were used for this purpose. The GHQ, a self-report questionnaire, was used to assess patients' perceptions of their general health status. The BAI₃₀, a largely observational instrument, was designed for purposes of the study, and used to assess relevant aspects of each patient's health status. Assessments were carried out on three "key" occasions: (A) on admission; (B) on discharge; and (C) after a post-discharge follow-up of 3-6 months.

The BAI underwent a number of standardisation processes, finally achieving 100 per cent validity and 50-75 per cent inter-rater reliability. Delivery of bridging therapy was based on a planned programme employing both hospital and community facilities. The Flexible Integrative Approach - a developmental approach based on the eclectic position in psychotherapy and nursing process and emphasising individual patient needs - was developed and employed for purposes of the therapeutic interventions in this study. These interventions included, e.g. rational-emotive therapy; reality therapy; and supportive psychotherapy.

The data collection phase extended over two years in the Sheffield context and approximately six months in the Cairo context. This differential was due to the time required to develop and validate the BAI₃₀, and to develop and evaluate the

therapeutic approach. Both the researcher and a consultant psychiatrist jointly assessed the patients using the BAI₃₀.

Statistical analysis of variance in experimental data demonstrated a highly significant improvement of the Sheffield experimental group regarding admission/discharge and admission/post-discharge scores ($p < 0.01$ and $p < 0.001$ respectively). This supports the effectiveness of bridging therapy not only in helping patients maintain achieved levels of improvement; but also to achieve further levels of improvement.

However, the Sheffield control group had also achieved significant levels of improvement during admission/discharge and admission/post-discharge periods ($p < 0.01$). Therefore, the hypothesis was only partially supported in Sheffield regarding effectiveness of bridging therapy; but its superiority to the conventional model was not supported. In Cairo again, significant improvement was obtained regarding admission/discharge and admission/post-discharge periods ($p < 0.01$ for both experimental and control groups). In other words, the improvement for the two groups was similar, which again does not support the superiority of bridging therapy over the conventional model. However, graphic presentation of linear trends demonstrated the higher tendency for better achievement in both experimental groups as opposed to their respective controls. These results should be viewed cautiously, bearing in mind the limitations of the study in relation to design and cross-cultural factors (see discussion, Chapter 6).

Outcomes of quantitative analysis imply that a number of independent variables indirectly influenced the course of this research. An attempt was made to illustrate some of these effects qualitatively by the inclusion of four detailed case studies, which illustrate the nature and scope of the therapeutic process. By examining these case studies, it becomes possible to recognise the interaction

between various factors influencing the effectiveness of care delivery:
particularly as these affect the quality and character of nurse-patient
interactions and therapeutic interventions.

In conclusion, the study appeared to be a useful exercise in the development of
new insights and approaches concerning comprehensive care and holistic
assessment within the context of cross-cultural evaluation research.

CHAPTER 1: Bridging Therapy in its Cross-Cultural Context

Introduction

- 1.2 The Research Problem
- 1.3 The Proposed Model of 'Bridging Therapy'
- 1.4 The Current Study
- 1.5 Research Aim and Hypotheses
- 1.6 Cross-Cultural Aspects of the Study Context
 - 1.6.1 Concept of Culture
 - 1.6.2 Socio-cultural Relationship to Mental Illness
in Egypt and Associated Cultures
 - 1.6.3 Epidemiology of Mental Illness in
Egypt and Associated Cultures
 - 1.6.4 Psychiatric Nursing in Egypt: Education, Work and
Attitudes towards Psychiatric Patients
 - 1.6.5 Treatment and Healing Approaches in Egypt and
Associated Cultures
 - 1.6.6 Research Problems Associated with
Cross-cultural Studies
 - 1.6.7 Western Style of Mental Health Care

CHAPTER 1: Bridging Therapy in its Cross-Cultural Context

Introduction

This thesis incorporates an evaluation of an innovative model of psychiatric nursing in hospital and community care in two cities, Sheffield in the United Kingdom and Cairo in Egypt.

It examines related nursing principles and techniques and applies a particular concept, that of "Bridging Therapy", as a proposed means of improving the discharge process from hospital to community.

Within the context of the proposed "Bridging Therapy", a particular approach to therapeutic intervention, evolved from the eclectic position both in psychotherapy and nursing process, was developed. This therapeutic stance was given the name of the Flexible Integrative Approach (FAI), it is discussed in greater detail in Chapter Three.

The research concentrates on a small group of patients in each hospital who were offered "Bridging Therapy" by the researcher who compared them with groups who received the standard nursing and medical treatment for their respective hospitals.

In order to develop this new model of care and place it in context, it proved necessary to review both the theoretical basis of psychotherapeutic approaches and the development of community psychiatric nursing (CPN) services during recent decades. The latter has been undergoing a process of reformation over the last thirty years, and attempts to establish an optimal service to meet patients' needs both inside and outside hospital walls are still under review.

Some authors such as Brooke (1959) and Mosher (1983) contemplate the eventual complete disappearance of mental hospitals; whereas others such as Jones (1972) and Bennett (1979) condemn the Government policy of closing down mental institutions, leaving patients to the cruelty of society.

The initial welcome and praise for community care services is beginning to wane after constant criticism from various disciplines including nurses, social workers and psychiatrists. Admittedly there are numerous problems which hinder the efficiency of the service provided by the Community Psychiatric Nurses (CPNs).

Skidmore and Friend (1984a) were able to examine the current CPN service in Britain and identified a number of the problem areas that could be studied and remedied. These areas were mainly associated with the education, specialism and practice of the CPNs. The organisational structure of the service was included as an associated factor rather than an independent factor. Their research was one of few such studies which are concerned with the evaluation of the service rather than merely a description of it.

Mangen and Griffith (1980) reviewed one hundred and twenty-nine articles appearing over the last thirty years covering different aspects of community psychiatric nursing care. They found that

" . . . much of it comprises descriptions of services, of goals, patterns of care and special aspects. There have been few evaluative studies."

Another study by Mangen and Griffith (1982a) examined the development of the service, concluding that it started on an ad hoc basis with no scientific plan or legislative policy.

All this has led to many questions being asked about the best possible service

that could comprehensively meet patients' needs. Reflections of models of care from other countries did not reveal any true means of eliminating the problems.

In the West, the USA has developed community mental health centres (CMHC) to serve patients in their own environment and restrict or limit hospital admissions. Theoretically these mental health centres would seem to be ideal for carrying the service to patients and their families in their own home, ie a natural environment rather than taking patients out of their home to an artificial protective hospital environment. However, in practice the CMHC service has fallen far short of expectations:

"They are unduly selective, failing in particular to serve the chronically ill and elderly, are isolated from the mainstream of psychiatry and therefore unpopular with psychiatrists, and ineffective both in reducing admission to state hospitals and implementing the preventive psychiatric programmes that were envisaged when they were set up."

(Tyrer, 1985)

Attempts made by other countries were studied by Singer and colleagues (1970) who visited the Soviet Union and The Netherlands to examine the community psychiatric services in Moscow, Leningrad and Amsterdam. They found that the psychiatric nurse in the Soviet Union has far greater responsibilities than her American counterpart. He/she is a nurse-social worker, (as there are no social workers as such in the Soviet Union) involved in the total care of the patient and in any social problems or environmental manipulation. The nurse offers general support and encouragement, watches for effectiveness and side effects of medication, gives injections to those who refuse oral medication, works with relatives and neighbours, and assists in social rehabilitation and readaptation. The therapeutic team in the Soviet Union consists of the psychiatrist and the psychiatric nurse-social worker.

The cities of Moscow and Leningrad are divided into health districts and each

district has a district psychoneurological dispensary (analogous to CMHC). These dispensaries provide emergency care, out-patient treatment, day care, night care and work therapy . At each dispensary there is one psychotherapist for children, one for adolescents and one for alcoholics. Each dispensary is divided into approximately ten divisions, each served by a team of one psychiatrist and one nurse-social worker; either or both of them make home visits as required.

However, they expressed concern regarding the real situation of the service, eg each health district with a population of 350,000 to 400,000 was served by only one psychotherapist; these were not allowed to make home visits which prevented them making a realistic evaluation of the quality of the service. In Amsterdam the outstanding example which they provide is the team approach; once again there is a close working relationship between psychiatrist and nurse. Hence care is an integral and important part of out-patient treatment. Nurses follow up cases on their own, handle the psychosocial aspects, adjust the dosage of medication and request the psychiatrist to see the patient at their discretion. According to the writers, this system of mental health care would be virtually the optimal development of community psychiatric care. Nonetheless, home visits made in Amsterdam demonstrated that patients with critical conditions were liable to be left in the community, causing problems for the families who then reacted in a hostile manner towards the psychiatrist and demanded hospitalisation for the patient.

A third system to consider is the Italian experience of "Psichiatria Democratica". A remarkable model of community care is presented by the Italian mental health system. Again in theory the experiment represented a revolution aimed at freeing patients from institutions and long term segregation in mental hospitals. The movement was pioneered by Franco Basaglia and his colleagues. Their efforts were influenced by the political situation in Italy, which followed the social

democratic party achieving power in the 1970's. In 1978 Basaglia induced the government to pass Law 180, which forbade the admission of any new patients to mental hospital and reviewed steps for their closure (Jenner, 1986). As a result the Italian Mental Health Act established legislation for the radical replacement of hospital psychiatric care with a community based service (Brown,1981).

Enthusiastic accounts in the British professional press regarded the Italian Experience as one of the great success stories of psychiatric history, yet empirical tests, conducted by Jones and Poletti (1985) suggested the opposite to be true. They found that mental hospitals were not closed down but lacked any maintenance or repair work, as they were officially closed. There were also some 'alternative structures' such as 'family homes' or 'villas', but in fact these were ordinary mental hospital wards under different names. The Diagnosis and Cure Units were disused, as it was impossible to diagnose and cure within 48 hours. The pleasant, informal Psycho-Social Centres turned out to be no more than out-patient clinics, with some community nurses (untrained but with mental hospital experience) attached. In southern Italy the problems became greater, eg in Salerno there were only 50 Diagnosis and Cure beds for a population of one million and there was no other service of any kind. Jones and Poletti found that dissatisfaction with this system was expressed by professional personnel in Italy and the government is now studying a proposal for the reform of Law 180.

These different examples of community care service provide a significant indication of the urgent need to find a satisfactory system based on empirical data and scientific outcomes that would act as a resource for planners in decision making.

1.2 The Research Problem

Discrepancy in the views about the best model for provision of mental health

care occurs not only between different countries from the east and west but also locally within the same system. In Britain, Beard (1980) identified three organisational structures which constitute the shape of the delivery of the Community Psychiatric Nursing service. These are:

1. Hospital based CPNs, working within multi-disciplinary or intra-disciplinary teams on the wards, in the day hospital, out-patient department or attached to specialist units such as behavioural therapy or drug addiction.
2. Primary Health Care CPNs based with general practitioners in single practices or health centres and with primary care colleagues such as health visitors, district nurses or midwives.
3. Social Service based CPNs working alongside area social work teams where intervention, supervision and education advice are on-going processes.

Skidmore and Friend (1984b) described a fourth model called the "Dual" ie based both in the hospital and in the Primary Health Care team. This model had the advantage of hospital support in addition to the involvement with primary care. Arguments as to which model is more effective are not concluded yet and are likely to continue. Sladden (1979) and Campbell et al (1983) were in favour of the community based CPN model while Kirkpatrick (1967) and Greene (1968) favoured the hospital based CPN model and Beard (1980) and Brooker (1984a) favoured the primary health care model.

It would seem that many writers have assumed that the way to improve mental health care is to abandon hospital care altogether. They wish to see community care as an alternative to hospital care. At present, this decision would seem to be premature; it may be preferable to regard community care as complementary to hospital care, (Tantam, 1985). Those who enthusiastically call for the closure of mental hospitals and regard discharge rate as indicative of improvement (eg

Brooke, 1959) rarely consider the meaning of 'community care' in practice.

More cautious commentators prefer to see better integration of the services (Hill 1968, Amesbury 1983, Tantam 1985). At present there are problems in the continuity and co-ordination of care for patients discharged from hospital. Bridging therapy designed by the researcher was an attempt to overcome some of these limitations.

1.3 The Proposed Model of Bridging Therapy

"Bridging Therapy" is the term given to the proposed approach for filling the gap observed in the delivery of the service between the hospital and the community*. This gap results in the patient's discharge to society without adequate support immediately after leaving hospital (Richmond Fellowship, 1983), and "Bridging Therapy" attempts to provide continuity of care immediately on leaving hospital.

The importance of this research problem is highlighted by Papelu (1952), Altschul (1972) and Mahgoub (1981), who emphasise the value of the therapeutic relationship between the patient and the nurse. Continuity of care by the same therapist has been identified as therapeutically valuable in studies by Baker (1968) and Lancaster (1980a). Furthermore there is some evidence to suggest that patients' liking of their therapists is significantly related to progress (Chassan et al, 1981).

Bridging therapy attempts to include each of the above elements in a model of care which may comprehensively respond to patients' needs. It views hospital

* This term is often loosely used, careful consideration of this term is detailed in Chapter 2.

services as part of the community service, so that a patient's care plan should continue after discharge to form an individual flexible and comprehensive approach. Other professions (psychiatrists, psychologists or social workers) have adopted the model of continuity of care by the same worker both during and after hospitalisation, whilst nurses are rarely offered the opportunity to continue their care in this fashion. Therapeutic interventions which take place within hospital wards could be of more benefit if continued at discharge and follow up by the same nurse keyworker.

Therapeutic care provided by the nurse keyworker should not be confined to simply promoting hygienic measures but, more important, in terms of helping the patient to re-settle in the community, helping the family to understand the patient's weaknesses and potentials and teaching both patient and family coping mechanisms and healthy adjustment behaviour. Their familiarity with the different facilities provided by the hospital and community centres, whether these facilities are in human or materialistic terms, can enhance the support of the patient regardless of the milieu.

1.4 The Current Study

In accordance with this principle, the researcher begins the bridging therapy programme during the period of hospitalisation by assessing the patient's needs and difficulties. She then employs different resources including the therapeutic team and the patient's family and friends in the therapeutic intervention, which continues after the patient's discharge from hospital for a period of between three to six months. During this time resettlement, adjustment and gradual independence can be re-established. Patients who will need longer periods of follow up are then referred to CPNs who are community based to allow gradual take over. The bridging therapy programme stresses three very important aspects of patient care:

1. the developed nurse-patient interpersonal relationship.
2. the flexible approach to meeting patients' therapeutic requirements (eg both in and outside the hospital).
3. Continuity of care by the same familiar therapist (nurse).

Clearly the bridging therapy model could be used as an alternative example of the organisational structure for the CPN service as patient care is certainly influenced by the organisational structure but this is not the focus of this study.

Bridging therapy is not another version of the model used in Moorhaven Hospital in Devon in 1957, nor a repetition of Peter Hunter's research of schizophrenics and their community care (1978). The bridging therapy programme is a structured evaluative approach which tests therapeutic variables and assesses their usefulness or effectiveness for the benefit to the patient. The subjects under study are neurotic or mildly psychotic patients whose problems are mainly behaviour maladjustment or family problems, rather than organic dysfunction or medication supervision.

A few problems were expected during the course of the research, eg role overlapping with other disciplines, nurses working shifts, lack of skills and abilities for effective intervention outside the hospital and intra-organisational conflicts. Fortunately, Maisey's (1975) survey pointed out that the participation of hospital based nurses in an after care programme did not affect the standards of in-patient care, although nurses spent one quarter of their working week in the community.

The problem of overlap was discussed by Hunter (1974) and Sladden (1979) with no resolution. Generally speaking the overlap problem should be viewed in terms of who does what? Personal observation indicated that the role of the psychiatrist overlapped with that of psychologists and social workers, occupational therapists

who run group therapy sessions overlap with psychiatrists and psychologists, similarly social workers overlap with psychologists and CPNs. Therefore the overlap between the CPNs, social workers, psychologists and psychiatrists is not unique and should be accepted as inevitable. With regard to intervention skills in the community situation, special training may be given for such purposes.

Another important aspect of this study is the implementation of the bridging therapy experiment in two different contexts and comparison of the results. In other words the development of the bridging therapy programme was to take place first in Sheffield and, if it succeeded in fulfilling its objectives, then it was to be transferred to Cairo, Egypt, to test its viability in a different context and different culture. The reason for this second test was to introduce a new type of service to the Egyptian mental health system which currently lacks any form of community psychiatric nursing care.

1.5 Research Aims and Hypotheses

Aim

The aim of this research is to examine the effectiveness of an innovative model of care that would comprehensively meet patients' needs both inside and outside the hospital. The model of care is to be used in two different cultures, Egypt and Britain, and its effectiveness is judged in terms of patients' outcomes.

From a quantitative point of view the null hypothesis would be that the current conventional methods of psychiatric care for neurotic and mild psychotic patients in Sheffield and Cairo, are as effective in terms of patients outcomes as 'bridging' therapy.

The Hypotheses are

- 1 That patients on an acute admission ward suffering from neurotic and mild

- psychotic conditions will experience greater benefit from continuity of psychiatric nursing care provided by bridging therapy than from current standard nursing care.
- 2 That these differences will be demonstrable in terms of:
 - (a) Standard psychometric instruments
 - (b) A newly derived behavioural inventory (BAI)
 - (c) Descriptive case studies.
 - 3 That the model of bridging therapy established in Sheffield is transferable to Cairo.

1.6 Cross-Cultural Aspects of the Study

Introduction

It is proposed that bridging therapy is to be employed in two different cultures, Britain and Egypt; that is to say, in a developed as compared with an underdeveloped (or developing) country. Reasons for such an approach are (1) to introduce the concept of community care to Egypt where such services are non-existent; and (2) to introduce an innovative model that could help to reduce the existing gap between hospital care and community care in Great Britain.

Therefore the following review will focus on seven main points of direct relevance to the current study. It must be noted here that cross-cultural studies tend to be rather broad and to place emphasis on major issues such as anthropological and sociocultural. It is not the intention of the current study to follow strictly these approaches. Examination of the phenomenon under study adopts the relevant principles of both anthropological and sociocultural approaches.

1.6.1 Concept of Culture

Culture is not readily defined in simple terms since it covers numerous aspects of life including economics, politics, social, biological, physical and environmental

factors and their associated psychological manifestations (Cox, 1977). In relation to mental health Cox quoted the definition of Kroeber and Kluckhohn, 1952 concerning culture:

"Culture consists of patterns, explicit and implicit, of and for behaviour acquired and transmitted by symbols, constituting the distinctive achievement of human groups, including their embodiments in artefacts; the essential core of culture consists of traditional (i.e. historically derived and selected) ideas and especially their attached values; culture systems may on one hand be considered as products of actions, on the other as a conditioning element of further action."

The importance of this notion is that it emphasises the relationship between mental health and culture and is reflected in the continuous efforts to find an answer to the question of whether mental symptoms are universal or culture bound.

At the beginning of this century Kraepelin tried to show that mental symptomatology is universal while Freud related it to culture and personality development (Kiev, 1972).

As a result concerns about what constitutes 'deviant' behaviour, 'normal' or 'abnormal' behaviour and socially oriented theories concerning 'labelling' and 'stigma' of mental illness were addressed by many authors such as Goffman (1961), Mangen (1982) and Armstrong (1983).

1.6.2 Sociocultural Factors Affecting Mental Illness in Egypt and Associated Cultures

Generally speaking the effects of environment and social life of patients on the development of mental disorders are described by Carstairs and Kennedy (1973) who used Wing and Brown's work in 1970 as evidence of the relation of social class to schizophrenic development. Further work by Brown, Birley and Wing

(1972) demonstrated that their educational programme for schizophrenic patients' families had produced significant reduction in the relapse rate of their experimental group over the control. In this study by Wing and Brown (1970), environmental poverty in terms of 'fewest personal possessions' was highly correlated with a 'clinical poverty syndrome' in terms of social withdrawal, flatness of affect and poverty of speech. Along the same line is Leff's (1982) experimental study of the influence of a social treatment programme for families of schizophrenic patients on the rate of relapse. In other words these studies indicate the importance of social (and cultural) factors in diagnosis and treatment of schizophrenia. Furthermore these studies were comparable with El-Islam's (1982) study of the effects of rehabilitation of schizophrenics by the extended family in the Arabian Gulf area. Results favoured the extended families as opposed to nuclear families in terms of supervision of medication, tolerance of minor abnormal behaviour and encouraging social skills and social contact.

In Egypt Abou-Zeid (1963) demonstrated that recent changes of the social structure of the Egyptian family are towards the nuclear family rather than the extended family. He regarded these changes as producing pathological effects in the shape of weak relationships among family members and the disappearance of family cohesion. Historically speaking, people in Egypt treated their mentally ill patients with dignity and support. In Pharaonic Egypt, temples were busy centres for sleep treatment or 'incubation' (a psychotherapeutic method associated with the name of Imhotep, the earliest known physician in history) (Okasha, 1977a). As the Islamic religion spread to Egypt, social and psychological diseases were recognised in the Koran with guidance for their management such as prohibition of drinking alcohol, gambling, homosexuality and suicide. On the other hand patients who were termed 'insane' were acknowledged in the Koran to be not responsible for their actions and forgiven in the after life (Okasha, 1977). Sadly this compassionate psychosocial caring attitude for the mentally ill changed

during the British colonisation of Egypt, and mental illness became a stigma as a result of the European claim of its genetic transmission.

Nonetheless, contemporary Egyptians try to help their patients and care for them as much as they can and as long as it is tolerable. However, as Abed El-Rahman's (1985) study showed, the majority of family members of psychiatric patients in the psychiatric out-patient clinic of Cairo University Hospital tend to deny the patient's mental illness. Instead, they gave other explanations such as overwork, school failure or loss of love object. They also expressed their shame and anxiety when they were unable to hide their relative's mental illness and recognised it as a stigma. They also admitted preventing their sick relative from sitting with guests or going out of the house.

Other studies by Chaleby (1986) showed that the presenting picture of patients with mental illness is mostly somatic. This is understandable in view of (1) the stigma of mental illness, (2) the historical tendency not to separate the psyche from the soma in conceptual terms, and (3) the tendency for physical illness to attract more attention in such societies.

Clearly in primitive societies, usually there is less separation between mental and physical illness (Carstairs, 1965, Lipsedge and Littlewood, 1979). Mental disorders are usually attributed to supernatural powers, evil spirits or witchcraft. These beliefs are widespread in some parts of Africa as well as among the non-educated groups in Egypt (Okasha, 1966). Such societies pay far less attention to the internal psychic motivations than is the case in Western culture (Kiev, 1972). Psychiatric disorders are usually conceptualised in terms of culture-bound concepts of role performance and normality. They also pay great attention to social determinants of behaviour, as the individual is believed to act in relationship to his ancestors (Kiev, 1972).

Egyptian families believe in the importance of the social role played by their family members even during their illness. Therefore they do not abandon their sick, elderly or feeble, no matter how impractical are the demands and responsibilities for their care. The sickness of one family member is the responsibility of all members of the family (Meleis and La Fevre, 1984). However on very rare occasions mentally ill patients who are chronically or severely disturbed could be abandoned if their symptoms become intolerable.

Both culture and religion reinforce this attachment which starts very early in the child's life with the maternal relationship. Govaerts and Patino (1981) found this biological attachment not only with the biological mother who breast feeds for a period of two to three years, but also with other female family members who share the child care.

To sum up, the Egyptian family take great responsibility for their sick members and only when it becomes impossible for them to continue such care for financial or other reasons, patients may be abandoned in Cairo's large mental hospitals.

1.6.3 Epidemiology of Mental Illness in Egypt and Associated Cultures

Epidemiological studies started to appear as attempts were made to demonstrate the existence of universal symptomatology of mental disorders concordant with the Western classifications. Initially the prevalence of mental illness in Africa was regarded as rare by colonial psychiatrists such as Tooth (1950) in Ghana, and Carothers (1953) in Kenya. German (1987) showed that recent epidemiological studies have indicated the opposite, i.e. higher prevalence of mental illness in Africa than in Europe. He indicated that early studies were influenced by two false beliefs: (i) Mental illness was part of the price that Judaeo-Christian cultures had to pay for civilization, for being responsible and for opposing the Devil; (ii) Africans are mentally backward, lack a sense of responsibility, their

brains are inferior, and they function in a childlike manner. He referred to studies by Kidd and Caldbeck-Meenan, 1966, Cox, 1979, and Assael et al, 1972, which all showed evidence of comparable psychiatric morbidity.

In these studies cross-cultural examination between Europe and Africa showed similar rates of psychiatric morbidity. The WHO (1973) International Pilot Study of Schizophrenia (IPSS) was a further attempt to standardise clinical diagnostic techniques. The study aimed at identifying shared cross-cultural symptomatology by using the Present State Examination (PSE) (Wing et al, 1967). Nine different countries participated in this project. Results indicated similarities of symptoms of schizophrenia among these different nations. However the IPSS outcomes varied inversely with social development of the society (Kleinman, 1987). These outcomes encouraged Orley et al (1979) to repeat the experiment in two African villages. They employed three techniques the PSE, the Index of Definition (ID) and CATEGO, a computer programme. Patients admitted to the hospital with acute disorders, were interviewed and examined using the PSE and ID. Their study confirmed 90 per cent validity and high reliability with the shortened version of the PSE (ninth edition) which omitted the section dealing with psychoses. Orley et al showed that depressive disorders are more common and more severe among a rural African female population than in analogous groups living in inner London suburbs.

Such epidemiological studies have encouraged psychiatrists in Egypt to pursue the same trend of applying Western classifications to non-Western patients (Egyptians). Thus Okasha et al (1968) studied psychiatric morbidity among a sample of 1000 patients attending Ain Shams University Psychiatric Clinic in Cairo. They used the European classification of mental illness. Results indicated schizophrenia as the commonest chronic variety of psychosis (15 per cent). Therefore they rejected Carother's statement that "paranoia, paraphrenia and

even paranoid schizophrenia are relatively rare among Africans". On the contrary, they found hebephrenia, followed by paranoia were most frequent.

Affective disorders were also common especially depressive anxiety neurosis 22%, hysterical symptoms 11%, obsessive-compulsive neurosis 3%, personality disorders 2%, and addiction 1%. Okasha and colleagues concluded that:

"Although the incidence and content may be different from European and other African psychiatric illness, most of the illness can be grouped under the same psychiatric nomenclature."

Following this the Egyptian Psychiatric Association formulated an independent Diagnostic Manual of Psychiatric disorders (DMP-1) in 1975, based on the International Classification of Disease (ICD-8) with a code system allied to the French Classification (Gawad, 1981). After the publication of both the ICD-9 and the DSM-III, Rakhawy (1978) suggested further revision of the Egyptian DMP-1 for simplification, coherence and consideration of cultural differences as well as fulfilling a better degree of common language with the international and other national neurological disciplines.

Studies of psychiatric morbidity in Egypt were criticized by El-Akabawi et al (1983) as limited to major urban centres and consequently not representative of the magnitude of mental health problems in the country. Therefore they set up a project to study the epidemiology of psychiatric disorders in an Egyptian rural village. The village was considered representative in many respects of rural Egyptian communities. It possessed water and electricity supplies, a police station, a primary and a preparatory school, a rural health unit and an agriculture co-operative.

Using the DSM-III, major psychiatric disorders accounted for 6 per cent, minor

disorders were 37%, organic disorders 2%, major depression 2%, mental retardation 1% and schizophrenic disorders 1% in a random sample of a hundred households i.e. 230 persons of both sexes. This study showed that schizophrenia had the lowest rate while minor psychiatric disorders were particularly high. These findings differed from the previous studies which were confined to University clinics, which is an indicator of the biased sample used in the previous studies. However El-Akabawi's study used a different diagnostic classification and took place fifteen years after Okasha's study.

Cross-cultural studies of depressive symptomatology were carried out by Gawad and Arafa (1980). Comparison of the symptomatological pattern of depression in the three samples from different cultures showed that there were significant differences in the pattern and frequency of the symptoms. However, the Egyptian and Indian studies using the same instrument (Hamilton's rating scale) were more comparable. Qualitative study of this phenomenon was suggested by the authors to find explanations for the obtained quantitative figures.

Cross-cultural studies appear to be of considerable attraction to psychiatrists in Egypt who are more interested in the epidemiological comparisons than in ethno-psychiatric aspects. Here again Okasha and colleagues (1978) conducted another study to compare psychiatric morbidity among university students in Egypt and their counterparts in the Western world. On the whole formal psychiatric disorders accounted for 2% compared to 5% in Edinburgh and 3% in Belfast universities. They claimed that the Egyptian figures could be misleading as many students prefer to contact private practitioners rather than attend the student clinic. Furthermore access to medication is available from the pharmacy without a prescription.

A recent work by Nasser (1986) compared the prevalence of eating disorders

among Arab female students both in London and Cairo Universities. Results indicated that 22% of the London sample scored higher than the cut-off score of 30 on the Eating Attitudes Test (EAT-40). No significant correlations were found between EAT scores, weight, height or length of stay in the UK.

In the Cairo sample, 12% scored positive on the EAT, with no significant correlation between EAT scores and age, weight or height. No cases either of anorexia or of bulimia nervosa were identified in the Cairo sample. Dieting was commonly by fasting two days a week (which is a familiar form of religious activity) as well as long distance walking (burning out calories). The subjects in the Egyptian sample were different from their counterparts in London. In contrast to the London group, bulimic tendencies such as binge-eating, self-induced vomiting and laxative abuse were characteristically absent; the subjects appeared to have had no knowledge that this kind of behaviour occurred. Nasser's results indicated the rarity of these particular eating problems among the female students in Cairo University.

1.6.4 Psychiatric Nursing in Egypt: Education Work and Attitude Towards Psychiatric Patients

The current status of the psychiatric nursing service in Egypt is an indicator of the problems contributing to the lack of adequate service for mentally ill patients. This section is a brief profile of this important problem which includes aspects related to education, training and attitudes. Because of a lack of literature some information is derived from the personal experience of the researcher, both clinical and academic.

1.6.4.1 Psychiatric Nursing Education

Generally speaking nursing is a very old profession in Egypt especially midwifery

which dates from the time of the Pharaohs (Iveson, 1982). However, it was only in the last fifty years that official training of nurses created interest, resulting in a better quality of care for patients and improved the public image of the nurse.

At the present time, nursing as a profession is struggling for identity and acknowledgement, a problem shared by other nurses in many parts of the Western world. The evolution of nursing education in Egypt, similar to Europe, started with unqualified, untrained personnel who joined hospitals to help the medical profession look after the patients. Many schools started to emerge and link with different general hospitals, university hospitals and special care hospitals.

There were two types of nursing discipline as shown in the following table:

Table 1.1: Early Nursing Disciplines and Training in Egypt

Discipline	Training	Previous Schooling
Hakima/Midwives	3 years	9 years
Nurse Assistant	18 months	9 years

These two groups of nurses were prepared at a general level, with no psychiatric nursing training either theoretical or practical (Abdel-Al, 1978). Recent advances both in patient care and nursing training abolished the previous two types of discipline. They are replaced by secondary nursing schools (3 years of study after 9 years of successful basic schooling).

Higher education in nursing at Diploma, BSc, MSc and PhD levels is encouraged and arranged by the Egyptian Ministry of Higher Education. These are mainly provided by a number of Higher Institutes of Nursing in different parts of Egypt. These require the completion of four years of general nursing study and one year internship, after twelve years of basic schooling; this includes three years primary

school, three years preparatory school and three years secondary school. Psychiatric nursing is studied both theoretically and practically both for undergraduate and MSc, PhD specialisation. At the secondary schools of nursing, it is studied theoretically only (Mahgoub, 1981).

One feature of the psychiatric nursing curriculum in Egypt is that it tends to be medically oriented. This could be due to the prominent influence of Western training of the psychiatrists and psychiatric nurses who shape, develop and teach these courses. Therefore more emphasis is placed on psychiatric classifications, symptomatology, psychopharmacology, physical therapy as well as psychotherapeutic measures of intervention, theories of personality development and influential social factors. Nevertheless the tendency to take a holistic approach to therapeutic intervention has grown strongly in the past few years (Rakhawy, 1980). Theoretically speaking this educational system could be very successful in improving the quality of psychiatric care. However, the actual situation is far from ideal. Maurad et al (1976) found that nursing is still looked down upon by the Egyptian community resulting in a small number of students joining the Higher Nursing Institutes. After graduation only 2% worked in hospitals of the Ministry of Health, whilst 36% chose to work in the Army which offers high salary and rank; and another big majority, 31%, chose to work in other Arab and European countries. The clinical fields of surgery, medicine, obstetrics and paediatrics were preferred to the administrative, public health or psychiatric fields. Mahgoub (1981) found that in Abassia Mental Hospital, the largest mental institution in Cairo, with a bed capacity of 3000, only two nurses had psychiatric nursing specialisation on completion of their Hakima course. The remaining 102 nurses possessed either a general qualification or were nurse assistants. In private mental hospitals the situation is worse as students of secretarial courses are employed as nurses whose only job is to supervise medication. Attendants who in many cases are illiterate are the real care

givers in most of these hospitals.

This diversity in nursing training extends to the highest levels of education where highly qualified Egyptian nurses visit Western countries to learn advanced methods of psychiatric care which are not applicable in their home country.

Their undergraduate training is also influenced by Western schools of thought as their teachers have themselves been psychiatrists trained in Europe or America (Leff, 1980). The teaching/training programme prepared for overseas students in the West caters for the health needs of the host countries with no consideration of its applicability to developing countries such as Egypt (Stones, 1972 and Lee, 1976).

To obtain higher qualifications at PhD level is a very difficult task for overseas nurses who have to adapt to a new culture and new system of health care delivery (Abu-Saad and Jones, 1981). After so many years spent in a European or American country and accustomed to a completely different life style, they have to return to their country and face another cultural shock. Cox (1986) identified this as a "double cultural" shock. In many cases overseas nurses try to work in the host country and settle permanently (Stones, 1972). Those who choose to go back to their home country face the difficulty of lack of resources which greatly diminishes their ability to apply their advanced skills and sophisticated education (Carstairs, 1973). Recognition of these difficulties and improvement of the training programmes were called for by Abu-Saad and Jones (1982). In addition to the educational difficulties, Cox's (1986) survey showed that overseas students' academic performance is threatened by many other social, financial and political factors. This was particularly of relevance at the time of the oppressive regime of Idi-Amin in Uganda, when the numbers of students who attended the mental health clinic increased by 50%.

Cox suggested that overseas psychiatric training should incorporate knowledge about the demands likely to be made on their return home. He added that these demands may include planning, training and evaluation of medical auxiliaries as well as teaching psychiatric nurses in developing countries. This is particularly true in Egypt, as psychiatrists in Egyptian universities participate in the planning and teaching of psychiatric courses for nurses in Egypt. On the other hand, health care professionals in the host country are also expected to develop intelligent awareness of the different cultural dimensions involved (Davis, 1986).

Research as part of nursing education is a very important achievement for nursing in Egypt. Experimental and evaluative research styles are most popular especially in relation to clinical and educational issues. Despite the economic distress, lack of resources, low wages, and limited educational resources, researchers in Egypt continue with their investigations in the hope of finding some solution for the countless problems encountered in every field. Many of these researchers have to finance their own research projects, as there are no funds for research as such. The Egyptian dedication to change and progress in spite of the economic constraints may make it possible to achieve some recognisable improvement in the foreseeable future.

1.6.4.2 Psychiatric Nursing Work and Attitudes

As previously noted, nurses working in state psychiatric hospitals usually have only general training, while nurses working in private hospital may not even have any nursing training. While many of the nurses in British hospitals have a psychiatric qualification there are also assistants who have no such training. Their proportion varies greatly in different hospitals. Surprisingly the WHO (1975) policy recommended the employment of general nurses in psychiatric services in the underdeveloped countries providing they receive some training for such duties. This was thought to solve partially the problem of lack of staff in

Egypt and other underdeveloped countries.

It was found however that the nursing contribution to patients' care in Egypt is limited to concepts of custodial care. Mahgoub (1981) looked at the effects of a group of student nurses working with patients on a ward, compared with another group of nurses running a ward and only dealing with patients as part of other ordinary administrative duties. Not surprisingly, the former group of patients showed a considerable increase in social and communicative skills. It turned out that the students had a case load of 1:4 while staff nurses had a case load of 1:25, a formidable case overload.

This also applied to the ratio of nursing to non-nursing activities. Abed El-Daym (1978) found that in El-Maamora Mental Hospital, Alexandria, Egypt, nurses spent only 12% of their working hours with the patients, while administrative and non-nursing activities account for the rest of the time. Concepts of custodial care are not only linked with the types of activities performed but also with nurses' perceptions of their identity and roles. For example Shaalan et al (1978) showed that nurses were anxious about the breakdown of authority barriers between patients and staff in a group therapy session. Shaalan and his colleagues' experiment in group therapy with Egyptian patients allowed nurses on the ward to participate in a rather sophisticated activity. This was particularly unusual as nurses in psychiatric hospitals are excluded from ward rounds and/or care planning. Mohammed (1983) found that psychiatrists both in a state hospital and private hospital prescribed a course of ECT sessions without consulting the nurses' observations concerning patients' behaviour after each of these sessions. Clearly some psychiatrists in Egypt view their work as independent of the nurses' contribution.

Nurses' attitudes towards mental illness correspond both to their personal

experience and the society influence. A study by Abed El-Kader (1981) showed that student nurses undertaking their psychiatric nursing course in the High Institute of Nursing, Cairo, exhibited higher levels of anxiety after the completion of their psychiatric clinical experience. She found that 77% had unfavourable attitudes toward their psychiatric nursing experience. Stresses encountered during their clinical experience were found to be: unacceptable patient behaviour 85%; patients' prognosis 81%; discrepancy between what is taught and the routine of the hospital 81%, the hospital atmosphere 79%, fear of excited/violent patients 75%, fear of catching mental illness 68%, and rejection by patients 66%. Her findings also showed that the majority of students developed symptoms of anxiety, insomnia, increased heart rate, headache, irritability, diminished concentration and fear.

Undoubtedly these findings indicate that psychiatric experience has negative effects on nurses' attitudes. This could also be explained by the negative attitude towards mental illness in Egyptian society. 'Negative' here does not mean punitive but refers to the tendency on the part of the patient's family or relatives to deny the problems, finding other names for the disorder such as "weak nerves" or "over-work" (Abed El-Rahman, 1985). Others may believe in supernatural powers and devil work (El Gueneidy and Williams, 1986), or may relate the problem to neurologic/organic disorder and seek medical and neurological help (Rakhawy, 1979).

Understanding of these cultural norms is of great importance both for clinical practice and educational purposes. This is particularly true for cross-cultural studies. Amin (1984) organised a cross-cultural nurse training course, to take place between the USA, Egypt, and Israel. Ten American students visited both Egypt and Israel for a period of three weeks, during which they examined the health care delivery systems; met with health care providers both in urban and

rural hospitals and had direct contact with peoples of these two nations.

Their most interesting finding was:

"The low incidence of child abuse and mental illness in Egypt demonstrated to the students how strong family ties in a traditional society can affect health behaviors. Family orientated care of the elderly in Egypt also demonstrated alternatives to the institutionalisation of senior patients so prevalent in the United States."

Clearly Amin's study praised the strong family relationships and preferred them to the USA system of institutionalisation. The paradox of this phenomenon however is not as simple. It was mentioned earlier that the Egyptian family usually choose to suffer the responsibility of care for their patients. On very few occasions as mentioned earlier, when the patient's care goes beyond their abilities, they may feel forced to abandon their relative to one of the large mental institutions in Egypt. In either situation, patients and their families suffer greatly from feelings of guilt and inadequacy. Therefore some form of community care system seems to be essential at this stage of development.

This community care system must ensure that it does not replicate some of the unfortunate types of Western system in which mentally ill patients were moved from hospital to boarding houses. On the contrary, it will encourage families to accept patients' hospitalisation when it is necessary to reduce unnecessary suffering; and to look after their patients when they are back in society. Hopefully such a strategy of early intervention could reduce the tendency to chronicity and help maintain families' sense of responsibility toward their relative's care.

This is not as simple as it sounds, as an adequate nurse training programme will need to be developed and different types of resources will need to be made

available. This fact is emphasised by the WHO (1984) call for help to patients and their families so that they can deal with their problems at a cost they can afford and with methods acceptable to them and their communities. Hopefully with such an orientation, successful programmes for community mental health care could be initiated for the benefit of Egyptian society.

1.6.5 Treatment and Healing Approaches in Egypt and Associated Cultures

Conflicting views about the aetiology of mental illness resulted in the development of different types of therapy. Western schools of therapy are discussed in Chapter (3). Here the focus is on traditional healing methods in developing countries.

1.6.5.1 Traditional Healing Methods

The term traditional healing is usually perceived in the Western world as referring to primitive methods of imaginary cure, particularly in relation to mental illness. Undoubtedly the ranks of traditional healers include some unscrupulous individuals with dubious practices (Leff, 1986); or quacks and thieves whose intentions are far from genuine attempts to help (Okasha, 1966). However, many of them are keenly intuitive and perceptive persons who make good use of their knowledge of people and human problems in helping their clients make the best of their situations. They give conservative advice, provide clients with outlets for potentially disruptive emotions and get substantial help from passage of time in solving clients' problems (Leff, 1986).

Leff (1986) drew the following comparison between traditional healer and Western doctor:

Table 1.2: Comparison of Traditional and Western Treatment Styles

Traditional Healer	Western Doctor
Deals in certainties	Deals in balance of possibilities
Gives answers	Asks questions
Aims at cure	Aims at management
Consultation public	Consultation private
Focus on client's social group	Focus on client as individual
Cause of illness often demonstrated	Cause of illness invisible
System of thought shared with client	Esoteric system of thought

Baasher (1966) related the success of traditional healers to a number of reasons

"Although this line of therapy is naive, primitive and based on no scientific grounds, yet it exploits the general psychotherapeutic principles of reassurance, persuasion, suggestion, abreaction, acting out, dream interpretation, emotional tension, relieving certain symptoms and producing social training and hopeful outlets."

In Egypt the non-medical or traditional healers perform an active role both in the management of physical problems (Abu-Zeid & Dann, 1985) and psychological disorders (Gawad, 1981). The latter explained that religious healers utilise the beliefs of Moslems and Christians in Egypt such as praying, visiting sheikh or priest, and Hegabs (sacred writing) as well as El-Zar Cult ceremonies.

Such methods work in harmony with the beliefs shared by many less educated members of contemporary Egyptian society, especially women who use such measures to exorcise evil spirits (Okasha, 1966). Europeans shared similar beliefs during the Middle Ages and through the Renaissance and on until the Counter-Reformation, since most mental disorders apart from simple idiocy were attributed to supernatural spirits (Asuni, 1986).

The most popular traditional healing cult in Egypt is the El-Zar Cult. It came originally from Sudan through Ethiopia. The term is an Aramaic word meaning 'Devil Visit'.

Okasha's observation indicated the effectiveness of the El-Zar Cult in the treatment of hysterical and affective disorders. He also found that patients with

obsessive - compulsive states, schizophrenia and severe depression did not improve. From a scientific point of view, Okasha produced a physiological explanation based on Pavlov's theory concerning how the brain might be wiped almost clean - at least temporarily - when exposed to certain stressful situations. It is a condition that makes the human brain reach a terminal collapse or stupor, after which some of the abnormal patterns seem to disperse and be replaced by the suggested healthier ones.

The same condition was identified by Giel et al (1968) as 'trance' or a state of complete absent-mindedness. He linked it with the psychiatric terminology 'dissociative reaction' or 'hypnosis' as essentially a state of altered consciousness. Giel goes even further by describing how we can partially be absent-minded, performing two mental activities simultaneously, one of which is automatic, like driving a car and at the same time being preoccupied with a meeting we are going to attend.

Csordas (1987) added another dimension to the concept of state of trance. He described it as 'normal' and that it is associated with the power the healers possess to cure their patients. He also believed that such power exercised, eg during El-Zar Cult, stems from the religious influence and people's perception of the healing process and its rituals.

Okasha (1966) described in some detail the El-Zar Cult as one of the most popular traditional healing methods used by many Egyptians for the exorcising of evil spirits. El-Zar Cult encompasses a number of procedures extremely important for its success. These involve the presence of a gathering of women, usually the victim's family members. The 'Kodia' or the healer leads the group in a ceremonial dance with very loud music until the victim reaches the stage of 'trance' and falls unconscious. Here the 'Kodia' will whisper a few words in the

possessed's ear and order the devil to leave the victim using the blood of a sheep slain for this purpose.

Arguments about the links between religious belief and traditional healing were raised by many authors. Some like Okasha (1966), Walker (1972) and Gawad (1981) refuse to accept that El-Zar Cult has any religious inspiration or motives.

'El-Zar is neither inspired by nor practised with religious motives. It is, in fact, in contradiction to religion, and it is Government policy to try to suppress its very occurrence.' (Okasha, 1966)

Conversely a field observation study conducted by Giel and colleagues (1968) in Ghion, Ethiopia, showed the strong relationship between religion and healing practice. Here an orthodox priest claimed that he cured more than one million people in fourteen years. Their field observation showed that the priest conducted the service among a crowd of several hundred people, used the Bible for readings and saying the prayers and approached the possessed by putting his cross against her forehead. Here again the priest ordered the evil spirit(s) in the name of God to leave the possessed.

In spite of the conflicting views of these authors, they all agree that the El-Zar Cult could be extremely helpful to certain types of patients. This may be explained in the view that El-Zar Cult is mostly used by women who are usually a socially oppressed group who need to obtain a 'secondary gain' of a spirit-induced illness (Csordas, 1987). Okasha's results (1966) indicated that all attendants of El-Zar Cult were women, mostly unhappily married, for whom the El-Zar Cult is an escape phenomenon and a means to abreact their frustrated desires. Their conclusions are also supported by Giel et al (1968) who describe the majority of possessed persons as women with hysterical problems, anxiety or hypochondriasis.

Incidentally these observations find support in the epidemiological study by Orley and colleagues (1979) about rural African females in Uganda. They found

depressive disorders among Ugandan women were approximately twice as frequent as among women living in inner London suburbs. Similarly, in Cox's (1979) study of psychiatric disorders among Ugandan pregnant women and non-pregnant women, the prevalence rates were in excess of rates reported from Europe, as reported by German (1987).

The other important observation drawn from the previous studies, is the strong influence imposed by the healer over his clients and the amount of suggestibility used in the process.

Baasher (1966) summarised the influential elements for the success of El-Zar Cult and the traditional healer in the following points:

- 1 Good initial preparation by usual cultural traditions, and conviction that this is the only means of abolishing their symptoms.
- 2 Full confidence and faith in this line of treatment.
- 3 The experience of the native healer in dealing with such 'clients'.
- 4 The continuous group involved and the use of this group in establishing mass excitement and suggestibility.
- 5 Full use of musical and sensory stimulation which excites the C.N.S.
- 6 Identification with saints and other historical and religious personalities.
- 7 Dramatization.
- 8 Meaningful utterances and suggestions during the dissociative phases after collapse.

The researcher would like to add another factor here, which is the fame of the healer among his people, since this encourages patients to be less defensive and more responsive. In addition, both Field (1960) and Leff (1986) indicated that the healer presents himself as possessed of special powers of understanding the nature and causes of disease and illness. His charisma is reinforced by his certainty that he knows the truth, he is expected to be able to discern the client's complaint

and its causes without asking questions and the treatment takes the shape of ceremonies for the client and his social group.

As previously indicated, patients with mental disorders in Africa and other parts of the developing world usually present with somatic complaints rather than psychological ones. This does not mean that they do not experience the psychological disabilities, but rather suggests the influence of the environment on the person's rating of priorities. In the developing countries where many epidemic diseases still pose a threat to human life and where governments allocate a major share of the health budget to combating such epidemic and endemic diseases it is scarcely surprising that personal emphasis falls upon physical symptoms, frequently treated both in Western and folk traditions by the use of potent pharmacological substances (Kiev, 1972).

Traditional healing methods are practised alongside Western psychiatry in Egypt. Awareness of the importance of this phenomenon helps better understanding between the patient and the nurse and/or the therapeutic team. It will help the nurse to understand some of the patient's expectations of therapy and the therapist. Bridging therapy, therefore, could help both the nurse and the patient and his/her family to find acceptable media of communication. In other words bridging therapy shares some of the traditional healing features, e.g. problems are assessed within their context and not judged only by Western psychiatric classification.

Members of the family are encouraged to share their views in the plan of management as well as the patient himself. Therapeutic intervention within the bridging therapy approach attempts to combat the patient's problems in a holistic manner rather than isolating one factor at a time. For example, patients with financial difficulties which may aggravate their depressive feelings, resulting in

deterioration of social and family relationships and hostile behaviour towards themselves and others, present a complex problem that needs intelligent awareness of all these interacting dimensions; and sensitivity while eliciting this information from the patient and/or the family. Intervention should examine the possible resource of financial help as well as the psychosocial support; and physical/chemical treatment when necessary. In that sense, bridging therapy may provide a meaningful approach to improving the mental health services that might have denied some cultural traditions. The following section is a brief account of Western psychiatric practice in Egypt.

1.6.5.2 Western Psychiatry in Egypt

In addition to traditional healing methods in Egypt, Western psychiatry is extremely influential and usually well accepted by the educated; whilst the less sophisticated tend to consider it only when traditional methods have failed to eliminate symptoms (Okasha et al, 1968). Psychiatric services in Egypt are mainly centred in the big cities such as Cairo and Alexandria. Nonetheless, gradual decentralisation of the service has been proceeding since the 1960's (Gawad, 1981).

The following tables provide a quantitative profile of psychiatric services in Egypt, as described by Rakhawy (1978):

Table 1.3 : Hospital and Outpatient Clinics

Organisation	Psychiatric Hospital	Psychiatric Unit in General Hospital	Out-Patient Clinic
Ministry of Health	7	20	39
University	-	9	9
Military Hospitals	1	2	3
Private Institutions	5	-	1
Total	13	31	52

Table 1.4: Total Bedservice and Psychiatrists

Organisation	No of Beds	Attending Psychiatrists
Ministry of Health	6,000	182
Universities	147	58
Private Institutions	460	25
Total	6,607	265

Psychiatric practice in Egypt follows the Western mainstream, and is dominated by no specific school of thought. Rakhawy (1979) points out that, with a psychiatrist/population ratio of 1:160,000, the psychiatrist can only adopt every possible 'useful' idea; and seek to apply any practical healing method in his struggle to cope with the crushing responsibilities with which he is inevitably confronted. The classical varieties of psychiatric treatment, including physical, chemical and psychotherapeutic approaches, are all in use. Rakhawy emphasises the difficulty of theorising in psychiatry and psychiatric practice in Egypt. He accepts that the predominant theory is 'no theory', or an 'eclectic' or 'multidimensional' approach: and claims that such a trend is both rational and practical in a developing country.

Unfortunately, the deteriorated economic status of Egypt has delayed many health service projects, particularly with regard to psychiatric services. In a country as economically depressed as Egypt, where debts stand at approximately 90 per cent of the gross domestic product, it is possible to provide only the bare essentials of care (Cooper, 1982). This massive economic deficit is aggravated by a high annual population growth of 2.19 per cent (Gomaa, 1984); by the monolithic system of nationalisation imposed under Nasser, which effectively precluded private enterprise (Abd-El Fadil, 1980); and by the highly selective, sophisticated and expensive care provided for the rich by entrepreneurs in response to Sadat's 'open-door' policy, which effectively drained human resources from a progressively more impoverished public hospital system.

In the rural areas, the Ministry of Health has long been committed to total provision of public health care for the population. It is estimated that some 97 per cent of the rural population now live within five kilometres of a health facility (Bryant, 1984). Nonetheless, funds are not adequate; there is no health insurance except on an extremely small scale; and the public health care service is curative rather than preventive. There are major problems in the control of communicable diseases; bilharziasis; malnutrition and eye diseases. Secondary health care of this type is responsible for far higher expenditure than is any other service (Mach, 1985).

Within such an economic context, it would be reasonable to expect mental health issues to occupy a relatively low expenditure priority. Paradoxically, this is not only the case in Egypt and other developing countries, but also appears to be true of Britain itself (Kiev, 1972). The WHO Technical Report (1975) emphasises the serious problem posed by mental illness in developing countries. Functional psychoses (ie, schizophrenia and affective disorders) constitute a large proportion of such serious disorders: and, in addition, mental disorders secondary to infectious illness and organic pathology are relatively common. Prevalence rates for epilepsy are higher than in Western countries; whilst other forms of mental disorder (ie, psychoneuroses, emotional disorders and personality problems) are more difficult to identify. In this report, overcrowding, unemployment and rapid social change, together with lack of modern health facilities, were regarded as important determinants which combine to make mental disorder a major problem.

In a more recent WHO Technical Report (1984), acknowledgement is made of some subsequent improvements in mental health services in the developing countries. However, it emphasises that the vast majority of the world population does not have access to mental health care, especially in cases of emergency. The report calls for decentralisation of these services, and their inclusion in

services provided by primary health care centres. This policy is in accordance with the WHO concept of health for all by the year 2000.

Although Egypt has operated a policy of gradual decentralisation of general health care since the 1960's, this policy has not been pursued as rigorously with regard to the psychiatric services, resulting in a serious disparity between urban and rural psychiatric care (Baasher et al, 1979). When such a decentralised psychiatric service was established in one of the rural areas of Egypt (Fayoum Governate), attached to Fayoum General Hospital, some significant effects were noted. The service included thirteen in-patient beds together with outpatient facilities. Baasher and his colleagues' evaluation of the project showed that a total of 918 patients used the service; and that the annual admission rate from Fayoum Governate into the two main mental hospitals in Cairo had dropped to almost one-quarter of its former level.

In summary, Westernised psychiatric services in Egypt are slowly growing, but there are still wide disparities between available urban and rural care. Although many studies have shown the high prevalence of mental illness, adequate funding for appropriate levels of service is simply not available. Western psychiatry is practised alongside traditional healing methods. However, traditional healers are not accepted by the Ministry of Health as legal practitioners. Professionals like Okasha (1966) and Abu Said (1985) are calling for official recognition of traditional modes of practice, with the provision of in-service education and licensing facilities. The WHO Technical Report of 1984 acknowledges the importance of this issue, and welcomes its implied use of all available community resources to promote the improvement of mental health care.

1.6.6 Research Problems Associated with Cross-Cultural Studies

There can be no doubt that cross-cultural studies have provided a refreshing new

perspective on issues related to psychiatric practice in the world context. Their importance is highlighted by the magnitude of the problem, since it is estimated that some forty million people suffer debilitating mental illness for at least ten per cent of their lives (WHO, 1975). Equally important is the fact that the majority of sufferers from mental illness in developing countries have no ready access to any kind of effective modern mental health care, and suffer unduly as a result. The reduction of such suffering demands the development of insightful approaches to cross-cultural research, including the acknowledgement and management of cross-cultural research problems. In this section a number of such problems relevant to the current study is discussed.

(A) Linguistic Issues

It has been suggested that certain phonetic expressions identifying emotional states such as anxiety, anger or anguish have specific somatic referents. For example, the French word "angoisse", from which anguish is derived, was described in the nineteenth century as associated with a feeling of constriction of the epigastric region and with difficulty in breathing (Leff, 1973). This author believes that:

'... people of lower class and poorer education tend to express emotional distress in somatic terms.'

A number of workers express the opinion that Egyptians tend to somatize their mental disorders (cf, e.g., Okasha et al, 1968; El Gueneidy et al, 1986) Chalaby (1986) found this to be more applicable to psychotics than to neurotics. The general proposition is in agreement with the findings of Harding et al (1980), that Africans predominantly present with physical complaints, even where the trouble is obviously of psychological origin.

The problem becomes specially complex when attempts are made to translate, and draw diagnostic inferences from, standardised Western psychiatric

instruments. Thus difficulties in achieving exactly equivalent terminology were experienced by Leighton et al (1963) in their survey of the Yoruba people of Nigeria. These workers used the Cornell Medical Index: but rapidly found that they had to supplement the instrument with descriptive terms like 'weak heart' or 'light heart' to describe anxiety or depression.

Similarly, Orley et al (1979) had to change the phrase 'READ your thoughts' to 'KNOW your thoughts'. They suggested the desirability of translating the concept underlying the words rather than the exact verbal forms: and believe that through this method certain psychiatric disorders such as depression can be successfully diagnosed, rather than resorting to the older, fallacious assumption that depression rarely occurs in Africans (Carothers, 1953).

Successful translation should also take due account of the cultural meaning of certain expressions. Thus Davis (1986) found that an African woman was diagnosed as schizophrenic after she described herself as 'coming from the moon' four months previously, and now trying to return there. In her own cultural idiom she was merely describing her amenorrhoea.

Communicative problems arising in the context of interpretation and cultural variation in this expression of the emotions are discussed by Cox (1977). This author draws special attention to the disparities between Western and African body language and its potential for inferential confusion. Similarly, Asuni (1986) points out that an African may suffer apparently severe depression on bereavement, which in his or her culture would be considered a normal reaction for which help and support would be available through the social network.

Conversely, Western psychiatrists would be likely to perceive such a reaction as an emotional disorder (depression) and prescribe accordingly. Asuni praises

African traditional mechanisms of family and social support, which appear able to deal with many apparent psychological disorders, to the extent that traditional healers are only consulted when normative methods fail.

(B) Research Techniques:

Many research techniques employed in cross-cultural studies are also questionable. Frequently the researcher appears to be preoccupied with implementing impressive scientific measuring techniques rather than dealing with the discovery of genuine cross-cultural materials (Foster, 1987). Foster criticises this tendency, and accuses WHO research committees of wasting many millions of dollars on such nomothetic research, which, though methodologically sound within a Western cultural context, does not reflect the real problems of developing nations.

Similar criticisms are voiced by Kleinman (1987) in his discussion of the International Pilot Study of Schizophrenia (IPSS) (1979). Kleinman found that personnel working on the project tended to ignore real data discrepancies, concentrating instead on certain 'broad similarities'. He also accuses them of 'clouding' their observations by seeking for familiar symptoms described in accepted protocols, whilst rejecting or ignoring less familiar ones.

Unfortunately, the effect of researcher bias towards the discovery of cross-cultural similarities and 'universals' in mental disorder may lead to a denial of real difficulties in the application of familiar and accepted techniques. A clear illustration of this may be seen in reviewing the work of Orley et al in a Nigerian village (Orley et al, 1979). Here the ninth edition of their Present State Examination (PSE) excludes the section previously included 'psychotic' symptoms. Apparently it proved too difficult in a primitive culture for these workers to differentiate between 'psychotic' and normal beliefs.

In addition, their advocacy of administration of the PSE by non-medical personnel is open to criticism. It reflects their apparent intention to employ 'human computers' who are perceptive only of symptoms recorded in the diagnostic protocol - and of nothing else. They appear to ignore contextual issues in behaviour, and the attributional factors that always determine its 'real' meaning for the social group.

In the Egyptian context, a study of psychopathology and social skills in chronic schizophrenic patients was conducted by Sobhy (1984). He used Arabic versions of the PSE (Okasha and Ashaur, 1981); Argyle's Relationship Rules (Ashaur and Hussain, 1982); and Susan Spence's Behavioural Analysis (Ashaur and Hussain, 1982). His findings revealed that his patients did not ask questions; did not use head movements or other non-verbal communication apart from eye contact (24 per cent); and lacked initiation of conversation or handling of the relationship.

However, such findings require interpretation in the context of Egyptian culture, where patients highly value their doctor's views and decisions; and it is not unusual for patients to be relatively passive and receptive in an interview situation.

Following Orley et al's (1979) suggestions, Sobhy restricted assessment to the clinical interview situation - a somewhat artificial setting for the assessment of social skills. In addition, no attempt was made to examine patients' social activities prior to hospitalisation, or to investigate pre-morbid personality. The pattern of research enquiry thus becomes a stereotyped reflection of the type of biased nomothetic investigation previously discussed.

By contrast, the work of Kleinman (1980) demonstrates awareness of these methodological difficulties, and presents suggestions for their reduction:

'The single most important concept for cross-cultural studies of medicine is a radical appreciation that in all societies health care and health care

activities are more or less interrelated. Therefore they need to be studied in a holistic manner as socially organized responses to disease that constitute a special cultural system: the health care system.'

The phenomenological approach to research in a clinical setting implied here is a difficult one, especially for psychiatrists steeped in the classical Western tradition of nomothetic enquiry. Emphasis in the phenomenological model lies in the situational reality and practical utility of research results, rather than on elaborate and elegant research design. Carstairs (1973) supports the realism of the approach, explaining that in the field of psychiatry, researchers will always be disappointed when their research design does not work, having failed to accommodate to the changed nature of the enquiry in the cross-cultural context.

1.6.7 Western Style of Mental Health Care in Great Britain

It is difficult to define a "typical" Western style of mental health care; since there are considerable variations between Western nations in this respect. In Britain the key care system is the National Health Service which, since 1975, has divided off priority services - i.e. mental illness, old age and mental handicap - from acute services, since they have very different requirements. Nevertheless, they all remain under the auspices of the Department of Health and Social Security (DHSS); which is also responsible for personal services such as welfare and social services.

The DHSS operates through various Regional Health authorities; which in turn delegate to District Health Authorities, who are directly responsible for hospital and community health services. These authorities work in close collaboration with various Local Government Authorities, which are responsible for various social welfare and housing services. The complexity of these arrangements makes it clear that much effective interaction and co-ordination is required at all levels. Unfortunately, this is not always achieved.

Historically, developments and improvements in the mental health services have been growing fast since the turn of the century. Since 1913, formation and revision of successive legislative measures concerning mental health has been an ongoing process (Templer, 1984). Related efforts to minimise compulsory detention issued in the development of successive Mental Health Acts (1959, 1983).

Steadily increasing emphasis has been placed upon humane features - e.g. open-door policies; establishment of therapeutic communities in mental hospitals; attachment of psychiatric units to district general hospitals; provision of day-night hospitals, out-patient clinics and community psychiatric nursing care. As the patient's need for independence and autonomy became increasingly accepted, further developments occurred which included the provision of half-way houses; sheltered workshops; and community day centres for rehabilitation and socialisation (DHSS, 1983). The system of psychiatric classification employed in Britain is that set out in the International Classification of Diseases (ICD-9) (WHO, 1978). Further details of community services and psychotherapeutic approaches are outlined in Chapters 2 and 3.

As a result of these developments, the mental health services in Britain are far in advance of those currently operating in Egypt. Funded partially through national health insurance and partially through tax contributions, the services are free at the point of use. Patients are referred by their general practitioner or by self-referral, usually initially to a psychiatric unit in a district general hospital. Most traditional mental hospitals still remain in use; but the intention is to close many down in the next decade. Specific psychiatric services are provided for special groups such as children and adolescents and the elderly. Therapeutic and support groups for alcoholics and drug addicts have been growing to provide the necessary specialised care.

Despite this highly advanced psychiatric service and the consistent decrease in numbers of hospitalised patients, the service still falls short of the comprehensive care intended: and many problems have been identified as inhibiting factors. For example, conflicts between different authorities as to who should do what may delay the delivery of services at the time when they are needed. Plans to move patients from hospital to community sometimes lack a realistic assessment of their requirements in terms of trained staff, accommodation facilities and budget (Bennet, 1984). Again, it had been thought that the transfer of patient care from hospital to community would reduce expense. This has not been shown to be true: in fact the reverse is the case, since patient care in the community has proved to be more costly (DHSS, 1981).

Continuous effort is currently being devoted to study areas of dysfunction in the service and to identify real causative factors, so that an optimal comprehensive service can eventually be established. In this context, bridging therapy may be seen as a small contribution in the process of linking hospital- and community-based mental health services.

CHAPTER 2: COMMUNITY MENTAL HEALTH SERVICES

- 2.1 Conceptual Base of Community Psychiatric Care in the UK and America
- 2.2 Legislative Aspects of the Development of the Community Mental Health Service
 - 2.2.1 Community Psychiatric Nursing Service in the UK
 - 2.2.2 Community Mental Health Care in the USA
 - 2.2.3 Community Psychiatric Care in Egypt
- 2.3 Historical review of Community Mental Health Service Development
 - 2.3.1 The UK
 - 2.3.2 Egypt
- 2.4 The Community Psychiatric Nursing Role
 - 2.4.1 The Ideology of the CPN Role
 - 2.4.2 Role Expectations
 - 2.4.3 Problems
 - 2.4.4 Cost Effectiveness
 - 2.4.5 Educational Preparation
- 2.5 A Review of Proposals for Modification of the Service

CHAPTER 2: COMMUNITY MENTAL HEALTH SERVICES

2.1 Conceptual Base of Community Psychiatric Care in UK and America

Concepts of patient care are continuously changing. The history of mental illness revealed a shameful deterioration of the service during the nineteenth and early twentieth centuries (Rees, 1957). Patients were segregated in mental institutions under very inhumane conditions and even severe punishment was sometimes enforced in order to protect the community from them. Then the attitude changed to protecting the mentally ill people from the cruel community which had put so much pressure on this vulnerable group of people. Protection thus provided a safe environment, free from pressure, difficulties, stress and problems (Barker 1981). At that time it was thought to be an ideal model of care whereby the patients and their families and the community at large escaped the responsibility of dealing with the real problem of healthy adaptation to living difficulties. As a result many patients were hospitalised for life, lost contact with the outside world, became completely dependent on the hospital's services and victims of the established system.

Awareness of this problem began to influence change following the second World War. Patients were freed from their cells, an open doors policy was introduced to mental hospitals and non-compulsory detention became available (Richmond Fellowship, 1983). In addition the discovery of phenothiazine drugs as effective chemotherapy to control patients' pathological behaviour has demonstrated the ability of many patients to lead independent lives.

Consequent upon the psychopharmacological development, the necessity of discharging recovered mentally ill people was recognised, with the

understanding that this group of vulnerable people continued to need professional support in the community. This initiated the idea of community care for providing patients living outside the hospital with the required care and after care, residential accommodation and preventive support. The Local Authorities held this responsibility under the National Assistance Act of 1948 (Sladden 1979).

This shift of care from hospital base to community implies that everybody could actively share in the responsibility for looking after mentally ill patients. (This will be discussed later to show further implications for effective dynamic community care.)

Community Psychiatric Care may be defined simply as: 'Caring for mentally ill patients in their localities and helping them to lead ordinary lives without the need of hospitalisation'. This simple definition does not identify the exact meaning of the community, type/range/quality of the services, work scope, patient and family requirements, community facilities, staff calibre, budget required, governmental policy and the development of the service. Some attempts were made at finding an explicit basic concept for community psychiatric care, yet it is still controversial.

Sladden (1979) reviewed the development of the concept from the 1950s, featuring the different legislative policies which have shaped the concept of community care. She found that, in 1950, the term 'community care' was hazy with no precise meaning. The Report of the Royal Commission on the Law Relating to Mental Illness and Mental Deficiency in 1957 made recommendations based upon two principles - the definition of mental disturbance as sickness, and therefore of mental treatment as a province

of medicine, and the separation of the medical from the social terms of care. Since psychiatric illness was regarded in no way different from any other kind of illness, it followed that people in this category of need should have equal access to the general social services provided by central and local government. It recommended a shift of emphasis from hospital to 'community care' and that local authorities should provide, in cooperation with the hospital services residential care, preventive services and vocational industrial rehabilitation and training, sheltered employment, day centres for the aged, social help and domiciliary advice. The new policies were given legislative effect by the Mental Health Act of 1959. Shortly after, the 'Hospital Plan' for England and Wales (Ministry of Health 1962) proposed the closure of many existing mental hospitals, and that adult psychiatric patient care should be re-allocated between new short-stay psychiatric units in General Hospitals and 'community care'.

The previous concept of 'community care' introduced by the Royal Commission Report was characterised by ambiguity and indiscriminately used to denote either a principle of administration or the actual range of services provided. Similarly 'the community' is used to denote both a social group and a territory. Therefore, the concept of community care depends upon how 'the community' is defined. Any definition could be loose and lack precision unless the actual concepts are interpreted in correspondence with reality. Sladden viewed the concept of community care as being interpreted in three ways:

1. Community care means care of social problems by social agencies
2. Community care means any form of care or treatment given without admission to mental hospital including care offered by medical or

psychiatric agencies

3. Community care means a comprehensive system of preventive psychiatry.

She found support for her definition in the writings of Caplan (1961) and Roberts (1966) who were concerned equally with groups and with individuals. Caplan's definition of community psychiatry initiated the basis of the current CPN service in the UK. He defined the general principles of prevention using a threefold classification.

- a) Primary prevention presents the processes in reducing the risk for people in the community of becoming ill with mental disorders
- b) Secondary prevention describes the activities involved in reducing the duration of established cases of mental disorder, thus reducing their prevalence in the community
- c) Tertiary prevention represents the prevention of defect and crippling among the members of a community through rehabilitation services which aim at returning sick people as soon as possible to a maximum degree of effectiveness

Through this outline Sladden arrived at the following concept which emphasised the relationship between mental health and reality:

"At a very basic level individual mental health is concerned with the person's relationship to reality and acceptance of this relationship. Therefore, to establish a common meaning for mental health there must first be a common meaning for reality. The simplest definition of reality is that it is consensus, that it is not limited to a specific group but incorporates the perceptions of multiple groups within

society. Individual mental health, then, would be defined as 'the ability to live with satisfaction within the consensually defined reality of one's society, behaving in a manner consistent with values, mores and norms of that society.' This definition is concerned with the relationship between the individual and the environment as opposed to a traditional intrapersonal definition that focuses on the person's attitudes and behaviour. Community mental health is then a state of positive opportunity for community members to relate to and influence in a significant, meaningful way each other and the society in which they live."

Further clarification of the term 'community care' was offered by the Richmond Fellowship Report on Mental Illness and the Community, 1983. The report warned against the misuse of the fashionable term 'community care' which entailed opposing admission to hospital irrespective of the alternative. It recognised the importance of a specific term of reference for the term 'community'. Generally speaking, the report perceived the definition of community as a geographically and administratively defined area, such as a borough or county; another meaning is a relatively well-integrated district or neighbourhood; sometimes the term is used to describe special communities created to foster certain groups of people with a common purpose, eg religious community, therapeutic community or sheltered communities for the mentally and physically disabled. This report adopted the first definition, which in turn fostered and promoted the second definition, ie it was the district's responsibility to provide 'community care' through statutory health and social authorities with back-up from housing, welfare, employment and voluntary services. This was done to promote the integration and limitation of possibilities of local residents feeling isolated and remote from help.

More recently the Report of the Select Committee of the House of Commons on the Social Services (1985), divided the concept into 10 categories, each subdivided into a number of items (up to 11). The most relevant category here is number 4 which defined the Health Services as:

"The term community care is imprecisely defined, it can mean everything and nothing. We emphasise the importance of its underlying values.

- 4.1 The term community care . . . are umbrella terms, used to describe a broad strategic policy of keeping people out of long-stay residential or institutional care, or facilitating people's discharge from such forms of care.
- 4.2 Community care is not simply about discharging people from hospital, it is about helping people not to be patients or dependent residents.
- 4.3 The term community care must be defined in a positive sense. It must say something about the nature of the care that should have been provided. It is not a low cost strategy for the abandonment of people in need, by decanting them from long-stay hospitals into cheap lodgings and isolated life of a wayfarer.
- 4.4 In the view of ADSS the term community care is appropriately used to describe a commitment to provide services, to support families and informal carers wherever possible, to substitute family care where the family is unable or unwilling to make provision and to use admission to hospital and residential care only where absolutely necessary. . . . The prime purpose of community care must be to prevent people being admitted to hospital inappropriately because of a breakdown in their network of family and social care.
- 4.5 The existence of a network of care services in the community capable of responding appropriately to a wide variety of individual needs, will provide the best possible framework to support those discharged from hospital who are handicapped by the effects of a long stay in hospital or in residential care.
- 4.6 Programmes of community care must respect and value the needs of individuals, give opportunity for choice and independence, assume that the least restrictive alternative in relation to the needs of an individual will guide the placement that is used and the service which is provided."

These attempts to reach an acceptable definition of community care were useful in destroying the illusion of satisfaction with the standards of the current service.

Jansen (1980) explained that community mental health services became a necessity to control the escalation in the numbers of the hospital population, despite the establishment of new asylums, eg in 1851 Colney Hatch in North London was established to take 1250 patients, it was gradually enlarged to take 2000 and by 1937 it housed nearly 2700.

It was during the Second World War that changes were initiated, new methods were fostered through the recognition of the fact that psychopathology was related to stressful environments, deficient group leadership and low morale, and consequently the so-called sick people could be helped by helping them to change their behaviour. The philosophy and methods of social psychiatry began to be developed in 1945 by Dr Tom Main at Northfield Mental Hospital and Dr Maxwell Jones at Belmont Hospital and their new experiment of a therapeutic community was studied by visitors from America (Jansen, 1980). The concept of the therapeutic community as defined and practised by Main in Surrey and Jones in Belmont was followed ten years later by Dr Dennis Martin at Claybury.

The first reaction, however, was one of very considerable hostility with fears that patients might soon be running the hospital and that nurses would lose all respect and authority. This hostility did not last long and the new philosophy proved to be successful in helping patients to regain their independence and return to the community.

The application of the therapeutic community principles was not easy. Its basic concept relied on social psychiatry and psychoanalytic disciplines as well as on fundamental humanitarian ideals. The concept of a therapeutic community was considered by Schoenberg (1980) as revolutionary as it opened up communication between isolated individuals through revealing suffering, healing and responsibility for each other. Jansen also recognised those elements as being the most important aspects of the therapeutic community:

"A wide variety of programmes and practice is clearly included within the term 'therapeutic community', but common principles dictate

that the therapeutic community whatever its context, should provide communal living experience which encourages open communication and promotes intrapsychic and social adjustment to maximum capacity of the individual."

Determined legal efforts to improve mental health care, were to reduce dramatically the mental hospital population and were accompanied by a corresponding increase in community resources (Jansen 1980). Miller (1981) expressed her dissatisfaction with the current practice of community psychiatric nursing care in the USA. She criticized a concept of community psychiatric care which was assumed to be the extension of existing psychiatric nursing practice to the community. Essentially the concept appeared to be limited to psychopathology and relied heavily on psychotherapeutic skills, while community assessment, preventive strategies or epidemiological tools were, in practice, used very infrequently in the community.

From the researcher's point of view the previous illustrated definitions were quite acceptable and very useful to implement, yet they stemmed very much from Western industrial countries where the problem of isolated societies and lack of support between family members is very evident.

One possible definition of community mental health care would be a multi-dimensional one which cannot be condensed into a few short statements. In other words, community mental health care is an organisational system which employs a wide range of social services at all levels in order to transfer the necessary care from any organisation to the individual patient, his family, friends or concerned neighbours. Community mental health care is a countless number of ongoing techniques that aim at the holistic approach for the sake of the individual or group. It makes use of different schools of therapy as appropriate and unique intervention for the prevention, treatment and follow up.

It is greatly influenced by the political atmosphere, society attitude, culture, religion and economic aspects. It provides a scheme whereby vulnerable people get to know how to survive in the community as well as leading the community to develop practical understanding of the patients' needs. It should be flexible, manageable, practical and comprehensive, with a clear level of understanding of the limitations imposed by different factors, whether human or environmental. Community mental health care is a continuous process which does not have an end as such, but which constitutes various levels of support of a contingency nature.

2.2 Legislative Aspects of the Development of the Community Mental Health Service

2.2.1 Community Psychiatric Nursing Service in the UK

Jones' (1972) review of the legislative procedures in community mental health showed that the first public announcement recognising community psychiatry as a possible alternative to hospital care was made by the Rt Hon Enoch Powell at the Annual Conference of the National Association for Mental Health in 1961. Powell's paper explained that this new policy was developed mainly on statistical terms which expressed that about 75,000 hospital beds would become redundant in the following fifteen years. He hoped that future hospital treatment would not be in "great isolated institutions" but in wings of general hospitals and that mental hospitals would disappear. According to Jones, the reactions to the new policy were both mixed and violent. Some, for example Dr Stanley Smith, believed that with the pharmaceutical age the days of the large purely mental hospital were over. Others, for example Dr D H Clark, expressed worries about the consequences of running down these hospitals. Furthermore, Mrs Bessie Braddock MP was particularly disturbed that the new policy had been introduced without consultation in the mental health field. Three

weeks later, a Ministry of Health circular (HM(61)25) gave a more detailed view of the new policy. As a result of statistical analysis conducted and presented by Tooth and Brooke (1961), who were respectively Principal Medical Officer of the Ministry of Health and a statistician from the General Registrar's office, suggested that there would be a decrease in the number of beds required from over 150,000 to about 80,000 in sixteen years. Jones suggested that

"The new service of the future would be four kinds of accommodation: acute units for short stay patients, usually in general hospital; medium stay units for medium-stay patients; units for long-stay patients, many of whom it was thought could be cared for in hostels or long stay annexes of general hospitals; and units providing 'adequate security arrangements for those whose condition makes this necessary', possibly on a regional basis."

The Ministry continued to plan for the new policy. In 1962 the hospital plan for the following 15 years was published, followed by the publication of "Health and Welfare: the Development of Community Care", in 1963.

As a result the sixties witnessed the development of psychiatric units in the district general hospital, the development of the antipsychiatric movement by Goffman and Laing, the appearance of the generic social worker, the disappearance of the Mental Welfare Officer and the struggles between the local authorities' new Social Services Department and health departments about who should be responsible for the mental health service in the community.

In 1968 the Seebohm Committee decided to include mental health work in the Social Services Departments (Jones 1972). In the seventies, under the Conservative Government, the same policy trends were continued and accentuated. A White Paper entitled "Better Service for the Mentally Ill" in 1975 was produced (DHSS, 1975).

This paper "Better Services for the Mentally Ill" proposed complete abolition of the mental hospital system within 15-20 years. It was planned to have all the provision in District General Hospitals which would include day patient, out-patient and emergency services as necessary.

Sladden added that alternative health services for non-hospitalised mental patients such as housing, accommodation and social services were further emphasised by the National Health Act 1977. The most recent law was the Mental Health Act 1983, which promoted patients' autonomy, need for independence and the regaining of control over their treatment or hospital admission. Compulsory admission became more restricted and used as a last resort. The after-care services were for the first time included in this new law; section 117 aimed at helping detained patients and providing home, occupation, support or continued medical/nursing care after discharge. Gostin (1983) criticised the delay of such action, which took 30 years to appear in the form of legislation. He also criticised the weakness of the resources suggested under section 117.

Whitehead (1984) discussed the limitations involved in the orthodox view of mental illness as a basis for the application of the law as well as the conflict between acceptance of mental illness as a medical problem and the impact of the law on human behaviour. Therefore, the existence of mental health legislation becomes a problem itself. He suggested that the new legislation, while accepting the need for society to be protected, should further guarantee the liberty of the individual. Although the new Mental Health Act 1983 has implemented this suggestion, its section on the after care services is not fully developed.

2.2.2 Community Mental Health Care in the USA

In the USA similar steps were being taken to free psychiatric patients from locked door hospitals and to enable them to regain their rights. According to Lancaster (1980b), USA legislation regarding community care began in 1955 when Congress established the Joint Commission on Mental Illness and Health with a mandate to study mental illness and make recommendations for a national mental health programme. In 1960 their report was published, recommending that mental health care should be provided within the community and be implemented by setting up regional centres with a maximum of 1000 beds and an emergency psychiatric service to be based in the community. In 1963 the Community Mental Health Centers Act was established, by which a broad range of rehabilitative services were envisaged covering prevention, treatment and after care. At the time when some writers were supporting the new legislation for community care, eg Karno and Schwartz (1974) in California, others were more doubtful about the real value of this policy, as reflected in the writings of Ochberg (1980).

Dissatisfaction with such legislation in the USA raised a number of problems concerning the actual practice of the Mental Health Centers (Ochberg 1980). These problems were a result of the numerous changes that have taken place in the ideology, practice and funding of community health efforts which proved incongruous, eg in 1980, 12 years after the first legislation, only 590 of the planned 2000 centres had been built, providing coverage for only 41% of the expected demand. Furthermore, Ochberg states,

"Economic recession, conflicts between the legislative and executive branches of the government, emphasis on revenue-sharing, block grants, regionalisation and expenditure control have impeded full achievement of the original intent of the community health legislation."

He also commented on the increased number of first admissions and readmissions and the inadequate system of referral for after care in the community after hospital discharge. The problem becomes even more complicated with regard to mentally impaired elderly people who have been discharged to substandard nursing homes without adequate supervision and therapy, or to boarding houses and old hotels where they may remain socially isolated and unemployed. Both Forstenzer (1980) and Ochberg (1980) urged the government to examine the use of public funding and to re-evaluate the existing federal and state legislation for the sake of developing a system of community care that would "fully meet the needs of the most seriously handicapped citizens."

2.2.3 Community Psychiatric Care in Egypt

The Egyptian Mental Health Act (1941) is currently in use; the concept of community care for detained patients is not included within this law.

2.3 Historical Review of Community Mental Health Service Development

The UK

The present community psychiatric care service has developed over the last thirty years (Hunter, 1974), yet it could be traced back to the eighteenth century when a form of social psychiatry took place (Carr et al, 1980). This period was called 'moral treatment' (Rees, 1957). During this era mental illness came to be regarded as a disease to be treated by a medical practitioner rather than by a priest. Attention was also paid to social and environmental factors in the causation of mental illness, as post mortem examinations failed to prove organic changes in the brain. Moral treatment aimed at relieving the patients by friendly association, internal discussion of difficulties and the daily pursuit of purposeful activity. Results of this treatment during this period were particularly

good between the years 1796-1861. An example is the number of discharges within three months of onset of illness of patients admitted to York Retreat; this was 71,117.

This social-psychiatric trend was first noted by the growth of privately owned 'mad houses' (Carr et al, 1980). In these 'mad houses' the moral climate was strongly preserved. Nursing, as such, was not introduced, care being provided by untrained attendants. The titles and roles of these untrained attendants differed greatly from one place to another and from one period to another. For example in France Dr Pinel approved the practice of employing recovered or convalescent patients to work as his assistants for patient care. His wife, Mme Pussin, gave the title of 'governess' to the female staff whilst the chief male nurse was known as the 'Governor' (Walk, 1961)

In England at this time there was no tradition of nursing either by religious communities nor by recruits drawn from former patients. The title 'Keeper' was given to staff working in the old Bethlem. With the appearance of Asylums (Wakefield Asylum 1818, 150-200 beds) the magistrates appointed a medical man (Dr Ellis, later Sir William Ellis) as superintendent but continued the practice of naming the superintendent's wife as the matron. The efforts of Ellis and his wife expressed the most advanced views of patient care. He called for

"... a group of highly gifted females willing from love of God and man to assist the matron in her anxious efforts."

During this period the terms 'keeper', 'attendant', 'nurse' and sometimes 'superintendent' were used quite indifferently and interchangeably; however, the term 'nurse' was generally confined to women and the term 'matron' to the superintendent's wife. The need for training of nurses and

attendants was recognised in 1854 and a call to improve working conditions was made by the Commissioners in 1855 (Walk, 1961).

A new system was adopted during the latter half of the nineteenth century in which asylums were transformed into large mental hospitals. A rapid decline in the service took place with hospitals becoming over-crowded and understaffed. Physicians lost touch with their patients and the office of chief nurse or "Sister" was separated from that of 'under nurse' to whom the cleanliness of the ward was committed. The Commissioners' Report in 1870 revealed that the strait jacket and other means of mechanical restraint had already returned to mental hospitals, that the bed capacity had increased from 400 to 600 beds and the overall discharge rate had declined from 50% in 1830 to 5% in 1880. The efficacy of mass production methods and the need for economy appear to have blinded the eyes of the legislators, whilst the growing materialism of the period, and the influence of Darwin were regarded by some as responsible for the decline in moral treatment (Rees, 1957).

Nevertheless, the important role played by the attendants in the provision of patient care was regarded by the commissioners who declared that

"under experienced and well-trained nurses the bad habits of patients have been removed,"

moreover they appeared confident that

"the introduction of even one or two such nurses into the workhouse would be of immense benefit to the patients who at that time had only their fellow inmates to care for them."

(Walk, 1961)

Therefore a formal course of lectures was arranged for mental nurses, given by Sir Alexander Morrison at Surrey Asylum in 1843-44.

Different courses were initiated by various people for the training of mental nurses. However the first nationally recognised training for this group was initiated by the Royal Medico-Psychological Association in 1890 (Hunter, 1974). These training schemes included making contact with the families of patients during the training of the novices,

"Moreover the novice should go with his patients to see the relatives at their visit and find out why and how the disease arose."

(Hunter,1974)

He also revealed that informal contact made between staff, relatives of patients and ex-patients was documented.

Despite these efforts the general picture in the late nineteenth and early twentieth centuries was quite different. The general view at that time was to secure the interest of society by segregating mental patients as cheaply as possible and to detain them for as long as possible, so that they did not reproduce themselves (Rees, 1957). This period was known as the custodial era. The successful campaigns of the eighteenth and nineteenth centuries failed to maintain the optimistic hope for recovery from mental illness. It became clear that claims for cures had been exaggerated. The custodial era was fostered by the Lunacy Acts of 1880 and 1891 which codified various legal restrictions on the freedom of the mentally ill. Such acts resulted in an increase in the patient population, overcrowded, under-staffed, poorly equipped institutions and strict control over patient behaviour by keeping them imprisoned in dark cells under inhumane conditions (Richmond Fellowship, 1983).

Some minor improvement took place following the 1930 Mental Health Act, when voluntary admission helped increase the hospital discharge rate and in addition occupational help was provided by some voluntary bodies

(Templar 1984). The greatest change took place in the 1950s when, due to major advances in pharmacology, treatment could be provided which had a significant effect on the control of disturbed psychiatric behaviour and which promoted considerable efforts in the initiation of changes in the function of the hospital. Doors became unlocked, restrictions on the freedom of patients were lifted and depersonalisation practices were combated (Hunter 1974). However, this recognised change only occurred in some hospitals and in many the change was minimal and poor conditions for both staff and patients led to low morale and bad practices. Nursing care continued to be inadequate and mainly domestic in nature, as those giving the care were not considered part of the therapeutic team.

The first formal development took place in extending the psychiatric nurse's role to work outside the hospital itself, either in caring for discharged patients or working with out-patients; this has taken place primarily in those institutions which have moved towards a therapeutic community and milieu therapy. Hunter stated that the first recorded beginnings of community psychiatric nursing care appeared at Warlingham Park Hospital, Surrey, in 1954. Beard (1984) related its development to the result of the drug revolution particularly the phenothiazine group. Chemotherapy controlled the psychiatric patients' disturbing symptoms and patients were allowed to go home with the help of professional supervision. This new situation revealed the need for rapid development of a community-based service. Phases of development of the CPN service were reviewed by Hunter (1974). There were mainly two phases: the first from 1954 - 1966 and the second from 1966 - 1974. Hunter described the first phase as "continuing care" and the second as "therapeutic work".

The first recorded beginnings of a community care service appear to have

been at Warlingham Park Hospital in 1954. Nurses were seconded to extramural duties in the Borough of Croydon. They worked from an office in the mental health centre attached to the Day Hospital. Originally there were two nurses but as the work grew two more were seconded. Regular supervision of patients formed a major part of the work. Moore (1964) described the principles underlying the work of those nurses as primarily clinical, where early identification of the patient's pathological signs and symptoms, supervision of medication, and close contact with other disciplines such as the Psychiatric Social Worker and Mental Welfare Officer, could take place. They worked under the supervision of a psychiatrist and formal meetings were held weekly to discuss and report on the cases.

Another phase of development took place at Moorhaven Hospital, Devon, in 1957. This service had a different organisational structure. Unlike Warlingham Park organisation, the emphasis was placed on continuity of care, working in hospital as well as with patients discharged from hospital. Moorhaven Hospital recognised the valuable therapeutic role played by the nurse. Four nurses were selected for this function, whose work involved physical medical care, psychosocial intervention, family support and education, administrative regulation of patients' admission to hospital or referral to other therapeutic disciplines, eg social worker or psychiatrist. The underlying principles were mainly concerned with the relationship between the nurse, the patient and the relatives.

Kirkpatrick (1967), Baker (1968) and Greene (1968) were in favour of the second model as it would be useful for the continuation of the therapeutic relationship between the nurse and the patient and would not disrupt the trust developed during the patient's hospital treatment.

However, in the Croydon model, nurses worked full time in after care and the supervision of out-patient treatment in the home, attendance at out-patient clinics, after care groups and social clubs following up patients who failed to attend. Again the functions of the nurses were described as purely clinical and were explicitly differentiated from those of the psychiatric social worker, so that overlapping between roles might be avoided,

"Detailed investigation of the patient's family situation or modification of his environment and of difficult interpersonal relationships is not expected." (May 1965)

This service was supervised by a consultant psychiatrist through weekly case-review meetings.

Similarities between CPN's duties and social worker's duties in this context were explicitly recognised at Moorhaven, and accordingly the scheme was supervised by members of the hospital's social work department to help nurses to deal with the new working set-up in home and family settings.

Nurses in this structure were able to work with the patients' families, providing advice, support, relieving anxiety and increasing their awareness of the social aspects of psychiatric disorders.

Further development was established through collaborative relationships (at some level) between the hospital and psychiatric services on the one hand and the mental health services on the other, in most areas. The functions of local health authorities in respect of mental health and mental illness were divided between the new social work departments and the established National Health Service. Specialist services for mental health work (Mental Welfare in England and Wales) were absorbed into 'generic'

social work agencies. However, social workers were not prepared clinically to undertake tasks required for after-care and drug regimes supervision which proved to be successfully covered by the community psychiatric nurses (Sladden 1979).

Dissatisfaction had been expressed in relation to the overlap between the social worker's role and that of the community psychiatric nurse, which is not yet resolved (Hunter 1974). Altschul (1969) pointed out the problem of the psychiatric nurse as a quasi-social worker in two aspects:

"The first question is whether or not the nurse brings to the work specific knowledge or skills, different from those of the social worker, and whether the nurse's learning or experience result in a different mode of functioning from that of the other professional people.

The second question is whether the patient has specific nursing needs as distinct from social needs and whether some patients require the nurse as a person rather than the social worker, to satisfy those needs."

The Local Authority Social Service Act 1970 tried to identify how social work in the psychiatric area should be organised and what specialisation was required by social workers. However, these issues provided an area of contention for social workers both amongst themselves and between some social workers and psychiatrists (Hunter 1980).

On the other hand Paykel and Griffith (1983) recognised that the advent of injectable depot phenothiazines for schizophrenics who were on an out-patient scheme had given the nurse a natural role as a keyworker which was developed towards comprehensive domiciliary care and extended far beyond the giving of injections.

This wider role and expansion of the follow-up services and involvement of different members of the psychiatric multi-disciplinary team gave

them priority over the mental welfare officers and the generic social workers who lacked specialist skills and produced a gap in the follow-up care.

Throughout the last ten to fifteen years the community psychiatric nursing service has seen much development and progress from a technical point of view. Many studies, such as those by Altschul (1972) and Kasch (1986), have supported the social psychotherapeutic role played by psychiatric nurses and trends for further specialisation that have taken place.

Nevertheless, from an organisational point of view, not very much has been done to reinforce the service and to ensure acceptable standards across different areas. Currently different forms of community services are provided according to the initiative and efforts of people at work. There is no legal mechanism by which the CPN service is set up or altered.

2.3.2 Egypt

To date there is no organisational structure for community psychiatric service in Egypt. Mental patients are cared for either by hospitalisation as in-patients or on an out-patient basis (Gawad, 1981). He explained that different types of therapeutic approaches are employed in both settings. Psychotherapeutic techniques for individual and group therapy, chemotherapy, physical therapy (ECT) and behaviour assessment are all used in hospital settings but there is neither a day hospital nor a night hospital. Statistics show that this system serves approximately 400,000 psychiatric patients in Egypt and for every working psychiatrist there are about 2000 patients. This is almost eight times the number of new patients seen yearly in European countries (Gawad, 1981).

The idea of treating psychiatric patients at their general hospital was adopted in the Egyptian system in the early 1960s, which saw the implementation of a policy of decentralisation of health care. Psychiatric units are attached to all general district hospitals and health centres. Nevertheless there are still two large mental hospitals in Cairo with a bed capacity constituting two-thirds of the total bed capacity in Egypt, ie about 3000 beds (Gawad, 1981).

The custodial model is the model used in these mental hospitals, where patients are still kept in locked door wards and are punished for their pathological behaviour (Mahgoub, 1981). Nurses in these hospitals are untrained, few are qualified and most of them play the role of the keeper, ie the same role played by nurses in the UK fifty or sixty years ago (Abed El Daym, 1978). The psychotherapeutic role is mainly carried out by the doctors who perform most of the duties of nurses and social workers - a situation similar to that of doctors in America in the 1930s (Romano, 1980).

Efforts have been devoted to improve the Mental Health Service in Egypt. This was at both educational and organisational levels. Higher education at the level of MSc and PhD is now available for interested members, ie doctors, highly qualified nurses and social workers who have completed university study at BSc level.

An unlocked doors policy is applied to psychiatric units attached to general district hospitals. Patients who are considered unsafe to be placed in open door units are referred to one of the two large mental hospitals where there is a locked door policy.

In common with Britain and the Western world in general, the neglect of psychiatric patient care in Egypt began to appear towards the end of the nineteenth and early twentieth centuries, with the first mental hospital in Cairo being opened in 1880. Before this time mentally ill patients were treated either in general hospitals or in their homes within the community. An extremely interesting example of this was at Kalawon hospital in Cairo in the fourteenth century, which provided a high standard of care during hospitalisation and convalescence in the community. This was a general hospital which included a department for mental disease as well as for surgery, medicine and ophthalmology (Okasha, 1977). Way back in the history of Ancient Egypt, priests treated patients in the temples (Romano, 1980). In these temples patients were treated with dignity and respect. Music, beauty of nature, recreation and occupation were all employed as remedial agents (Romano, 1980). They also implemented a specific therapeutic method called "incubation" or "Temple Sleep". This method was associated with the name of Imhotep, the earliest known physician in history. His temples were busy centres for "incubation" or sleep therapy. The course of treatment depended on the individual patient's manifestations and dream content (Okasha, 1977).

Until recently the Egyptian community provided mentally ill patients with sympathy and support in the initial phases of their illness, so that, hopefully, their illness would not get worse and they might be able to effect a cure. However, mental illness is now considered a stigma once it has become chronic and the hope for a cure disappears. Traditional methods of healing such as El-Zar (a type of music therapy) are used and some neurotic or hysterical cases are successfully treated by this method (Okasha, 1966).

In contrast to the regrettable periods of oppression throughout the Middle Ages in Europe, when psychiatric patients were accused of demonology and witchcraft, and even burned to death, Egyptians treated their mentally ill patients with compassion and dignity. It was only in the late nineteenth century that European attitudes of apathy and neglect for chronic mentally ill patients were adopted by Egyptian health planners. The belief that mental illness is not curable and is genetically transmitted dominated public thinking and attitudes. Thus, similar to the British system of psychiatric care, patients were segregated in distant mental hospitals, imprisoned for life under inhumane conditions. The recent development in chemotherapy and social care has initiated a strong argument for closing down these hospitals; a policy that has successfully resulted in decreasing the bed capacity of Abbasia Mental Hospital from 3000 to 2000 beds. Many patients now receive out-patient treatment, admission is only used if really necessary and then it is usually voluntary, Involuntary admission is very rare and is now controlled by the Egyptian Mental Health Act of 1941.

Occupational and recreational therapy are widely used in these mental hospitals but without the application of therapeutic community principles. A need for improvement is recognised and practical steps for change are currently taking place.

2.4 The Community Psychiatric Nursing Role

2.4.1 The ideology of the CPN role

Two different approaches could be followed to define the role of the CPN. The first one would be to give a simple and clear description of the tasks and duties expected to be achieved by the CPNs to reach the goal or aim set for their service. This approach has been used for the last thirty years,

as will be discussed later.

The second approach is to study in detail the different elements in establishing certain services; the community needs; the ideology and ecology of development; available facilities and constraints, and the prospects for success.

Nursing in general has been going through an era of confusion where a search for identity and established role is continuing. CPNs have been confronted more with this confusion as their service has developed, starting by filling the space left by the shortage of social workers in one particular area. To find an acceptable definition of the role of the CPN that would end the confusion, resolve the overlap problem and establish identity is quite difficult: the reason for this could be that nursing is not seen as a science in its own right, but its body of knowledge is built up by adoption of the theoretical basis of other specialisations, eg medicine, psychology, sociology. For many years there were no psychiatric nurses and care was only given by attendants (Hunter 1974), care being purely custodial.

The typical features of custodial regimes were identified by Sladden (1979) as

"A stereotyped concept of mental disorders as irreversible disease processes, characterised by behaviour devoid of meaning and rationality, for which sufferers should not be held responsible; an overriding concern for the maintenance of order and control expressed at ward level in an arbitrary system of privileges and penalties; a rigid differentiation of status levels between staff and patients, and between staff groups, impersonality, distrust and alienation in attitudes and relationships."

With the development of the new movement towards the 'therapeutic community', the psycho-social model, the open door policy and the early

discharge of patients whose symptoms were kept under control by the use of psychotropic drugs, the custodial regime became irrelevant and a change to the psychotherapeutic model of care was encouraged, supported by different national and international committees and conferences. Reports made by the WHO in 1956 and 1963 produced a typology of psychiatric nursing skills which included a wide range of skills such as technical basic skills, occupational and recreational, organisational, interpersonal, observational and communication skills.

The value of the psychotherapeutic role of the nurse became very fashionable in the late 1960s and early 1970s and was supported in literature. Altschul (1972) gave a detailed review of the literature bearing on "relationship therapy", "nursing therapy" and "therapeutic intervention". Peplau (1952) defined the psychiatric nurse role entirely in terms of interpersonal techniques and responses, describing it as "the crux of psychiatric nursing". Further literature identified the problems formulated in a therapeutic interaction and suggested guides to improve communication skills, provision of empathic relationships both in individualised and group therapy, conscious control of the nurse's behaviour and goal directed words and actions (Sladden 1979).

Hunter (1974) grouped the therapeutic work of the CPNs under five components:

- continuing care service
- crisis intervention/group work treatment
- psychotherapeutic treatment
- psychogeriatric assessment and treatment service
- behavioural therapy.

Hunter supports the development of the CPN service and provides evidence of considerable support for this "extension of the nurse's function" from a number of recognised agencies, eg Royal Medico-Psychological Association, the Association of Psychiatric Social Workers and the National Association for Mental Health. They based their support on the fact that the CPN's role is:

- "a) That the nurse can be of service to the patient and his family in a practical way. Bathing . . . shaves . . . etc
- b) As a link between patient and hospital so that the patient can be readmitted quickly in case of relapse . . . etc
- c) To give support, advice and supervision . . . eg, drugs and injections
- d) Giving a continuous care service to particular categories . . . etc
- e) A 'preventive' role
- f) Recognition of the side-effects of medication and taking appropriate action in co-operation with GPs and psychiatrists
- g) Investigating the reason why patients fail to attend the day hospital
- h) Helping with social clubs and other forms of groupwork
- i) Job and accommodation finding
- j) Supervision of out-patient clinic."

This definition does not imply that each individual nurse would carry out all of these functions at any one time; Hunter claimed that it represented an analysis of the different descriptions given to the work of the nurse prior to 1967.

However, there has been dissatisfaction expressed by many psychiatrists and nurses at the loss of social workers specialising in work with patients

suffering from psychiatric illness and with their families. Along similar lines to Hunter's view, Henderson and colleagues (1973) described their experiences in establishing a Domiciliary Psychiatric Treatment Service (DPTS) at the Ross Clinic, Aberdeen, in 1969. This scheme was based on the concept of teamwork (a female psychiatric nurse, a male social worker and a consultant psychiatrist). The psychotherapeutic role of the nurse was greatly emphasised and marked a cornerstone in the activities of the nurse.

Greene (1968) provided a more advanced view of the CPN's role which conflicted less with the role of social workers. He summarised the current thinking on the nurses in the community as:

1. Provision of nursing care of a physical and psychological nature in accordance with the doctors' wishes for patients who have been discharged from hospital and are in need of nursing care (eg supervision of drug treatment or observation of depressive conditions)
2. Working in close liaison with doctors and social workers as professional members of a therapeutic team
3. Extending to the patient and his family such support as may be reasonably regarded as part of a nurse's work
4. A preventive role, in going to the aid of patients whose illness does not require treatment in a clinic or hospital
5. Being available in a consultative capacity to non-psychiatric nurses

who may have problems with patients showing symptoms of nervous and mental disorder.

No doubt each of these developed from progressive trials analagous with the development of the service over the years and emphasise the particular areas in which the CPN has something special to offer.

The experiment of Stobie and Hopkins (1972) is an outstanding example of the role of the nurse in crisis intervention. The experiment took place in Dingleton Hospital, Melrose, where psychiatric disorders were seen as manifestations of a disturbed interpersonal process, and, therefore, attention was focused on the family situation as opposed to a "sick" person. Psychiatric crises were used as an opportunity to help people find more productive ways of resolving their personal and interpersonal problems or conflicts.

Stobie and Hopkins recognised the nurse as a member of a multi-disciplinary psychiatric team who had special functions necessary for the operation of the team. They described seven elements which constituted the function of the nurse:

1. Participation with other disciplines in assessment of patients and their families
2. Participation in the intervention in crisis when admission has been requested (physical treatment used when it promotes resolution, not avoidance, of crisis)
3. Participation in family and marital therapy
4. Mobilisation of community resources and help
5. Supportive care of long-term patients in the community and help in

the supervision of drug therapy

6. Prevention of regressed and maladaptive patterns of behaviour in coping with stress
7. Functions connected with integration of the team's activities with liaison and consultation between the team and other professional community workers and with mental hygiene education in the community.

In theory this example of "crisis intervention" using the multi-disciplinary team method would appear very helpful to patients and their families and it would also be supportive for the nurse who would feel capable of decision making due to open channels of communication with other specialties and disciplines. However, in practice, according to Altschul (1973), this system did not work. She found, in her investigation, that evidence of differential use of professional skills was not obtained but on the contrary the hospital culture emphasised the similarities in function, blurring and overlap of roles and absence of role specificity. Gallagher (1982) looked at the psychiatric nurse's role in the community, which was considered to be of an exacting nature. It developed from being merely an inspector of the depot drug into a more comprehensive role. According to Gallagher, the community nurse's role is of particular importance in four specific areas: crisis intervention, behavioural psychotherapy, dynamic psychotherapy and family therapy.

Carr, Butterworth and Hodges (1980) were able to outline the role of the CPN in a more systematic way. They used Barker's (1977) description of the role of the CPN in four main areas: the nurse assessor, the nurse consultant, the nurse therapist and the nurse clinician. They then added two further aspects: the nurse as an educator and as a manager. They

recognised that these six areas encompass most of the component parts of the role of the community psychiatric nurse and that most present-day CPNs are involved in all the areas mentioned.

In more detail, their conception of the role of the CPN was:

1. As a consultant for both patients and other professionals
2. As a clinician to undertake nursing action of a technical nature
eg injection and maintenance of physical care
3. As a therapist who provides and transfers therapeutic activities of psychotherapy and behaviourism to the community
4. As an assessor, to assess the requirements, care delivered and its effectiveness
5. As an educator to tell people about potential hazards of mental disorders, curative aspects and more importantly preventive aspects; this is in addition to educating nursing students
6. As a manager to handle the complexities of communication in the community setting and organisation of work priorities

Many CPNs already concentrate on such areas and, furthermore, seek to specialise in specific techniques such as behavioural therapy or alcoholism treatment. This attitude is not favoured by Carr et al who perceive the overall aim of the community psychiatric nursing service as the comprehensive delivery of psychiatric nursing skills to the community before any further specialisation can be realised.

Horsfall (1983), in Australia, argued in favour of psychiatric nurse specialisation and considered it essential for two reasons:

- a) The bulk of psychiatric patients can no longer realistically expect to have a psychiatrist or even a psychologist as their main therapist, simply because these specialists are already overloaded in clinical time with the severely mentally ill.
- b) Some writers believe that nurses frequently tend to reinforce patients' odd behaviour and ignore pro-social behaviour. Therefore nurses should receive more explicit training in correct behavioural change techniques in order to gain specialised techniques to allow them to help reverse the institutionalising process.

The traditional role of a nurse as only a 'carer' is becoming very dubious. Evidence is now filtering through from different countries that psychiatric nurses who have been trained as therapists are proving to be very useful and are playing an influential role in both treatment and prevention programmes for the acute and chronic psychiatric patient.

In general, Horsfall sees mental health nurses, especially those who work in the community, as very influential, powerful agents who could work as specialised therapists particularly in behavioural and cognitive modes of therapy. Hall and Russell (1982) also support this view of encouraging CPNs to be independent, influential agents whose extended role would aid the development of a truly community-based, community oriented service,

"the nurse could then become a professional consultant."

In America the role of the Community Psychiatric Nurse is still under much criticism and striving for better recognition despite the fact that CPNs there have overcome the problem of lost identity and many of them

are recognised as specialised nurse therapists in the field of community care. Nevertheless success in meeting consumers' needs is doubted (Lancaster (1980)).

However in 1981, Miller, from Virginia University, expressed her dissatisfaction with the present role played by CPNs. She sees that they have moved away from their real community role to take over the psychologists' role and now work as psychotherapists purely because it has become more fashionable in the last ten years. She believes that preventive intervention and community assessment lie at the core of mental health orientation in community mental health practice. She urged that CPNs should study the community and its meaning, and convey this to their patients before they can begin to decide on assessment criteria and intervention processes. Similar to Miller, Lancaster (1980c) looked in depth at the ecological perspective in community mental health nursing.

Lancaster views community mental health by applying an ecological approach that would recognise the complexity of the problems but would not take simple solutions that might create more havoc rather than provide a cure; also the ecosystem perspective shows that it is no longer tenable to consider mental illness as the result of a single cause. Lancaster described an application of ecological principles to community mental health which embodies concepts of prevention. She used Caplan's three levels of prevention. Bruhn and Cordova (1980) had also emphasised the ecological approach of practice and were able to add another dimension which is to get sufficient information about the subject, and in order to do that the CPN should, therefore, be flexible and adaptable and use this information for the benefit of the patient. They concluded that such an approach would minimise the chances of premature judgement caused by

insufficient information.

The above review of the role of the CPN service shows that it is still struggling for recognition of a consistent and acceptable identity. Some writers saw the struggle as continuing for a number of reasons. For example, Bloom (1979) has argued that it is difficult to determine definitions of mental health and community mental health services, while Sladden (1979) referred to the conflict between local authorities, the NHS and the DHSS about who should do what in money terms; and Hunter (1980) pointed out the confusion encountered with the overlapping of responsibilities between social workers and CPNs.

2.4.2 Role Expectations

This complicated issue of the role of the CPN is not impossible to resolve. The following suggestions explain how community mental health care could be conceptualised in a more realistic way.

First: the role of the CPN is very much linked with society. The rapid changes in today's society impose rapid changes in the patients' needs and consequently changes in expectations of what the nurse can offer.

Expansion, extension and specialisation are all necessary elements of the living process and are, therefore, basic to any profession and specifically to CPNs.

Second: this natural phenomenon of expansion, extension and specialisation of CPNs appears to be a 'double-bladed sword'. It is a healthy phenomenon, in that it proves that nurses can adopt and acquire new skills and employ these wherever necessary; but it could be a very dangerous phenomenon when the expansion exceeds human limits and

relies heavily on hypothetical abilities which the nurse, like any other human being, may not be able to provide. The failure to acknowledge such difficulties may result in chaos. In other words some writers have been very enthusiastic about the emergence of CPNs and their input to the service for the last thirty years to the extent that they perceived the CPNs as a section which will do anything and everything needed for patients to restore health and prevent illness.

Third: to date the expansion/extension role has meant the addition of tasks and responsibilities previously carried out by other professions, eg social workers, psychologists, psychiatrists or GPs. Nursing has for many years been the 'basket' which has received delegated responsibilities from all other professions. This can be explained in the light of the absence of a body of knowledge known as the science of nursing. Unfortunately, so far, many view nursing not as a science in its own right but like a basket filled with bits and pieces of other sciences which were given by other professions, aiming to delegate some of their responsibilities to nurses either because they did not want them any more or because they were overloaded and the nurses could thus help relieve them.

For instance, the WHO (1956) saw nurses as working with families to improve disturbed relationships, deal with financial problems and employment difficulties and arrange and supervise boarding-out care. Therefore the nurse should act as a friend giving advice, entertaining patients and supporting them to solve their problems; should act as a mother who will carry out the necessary physical care for patients in the community; should act as a teacher to patients, their families, student nurses, and colleagues from other specialties; should act as a manager for organisation at an administrative and personal level. In fact no other

discipline is treated as super-human as are nurse professionals and considering the educational preparation, such expectations are both unrealistic and reveal a lack of awareness of the actual scope of the nursing profession. From a personal point of view the provision of an efficient, relevant and effective community psychiatric nursing service that will fulfil all the above expectations is not viable. Support of this view is found in Sladden's examination of the concept of the social role. She stated that

"Role expectations are essentially social and are conveyed to the individual via members of his 'role set' through the expression of approval or disapproval. In other words role expectations are perceptual and are enforced on the individual holders of the role by social acceptance and regard for their fulfilment, or by social rejection and punishment if they are violated."

Furthermore, she found in an

"American study specifically concerned with ideology of psychiatric treatment, Strauss and his co-workers (1964) found that nurses were inclined to endorse whatever ideology (psychotherapeutic or sociotherapeutic) was dominant among their medical colleagues and that as an occupational group they showed no attachment to any particular set of ideas."

2.4.3 Problems

So far there have been some controversial attitudes towards the service, some supporting the service whilst others question its value. Amongst the supporters Henderson et al (1973), Walker and Brook (1981) and Hall and Russell (1982) all gave evidence of the success achieved by psychiatric nurses working in the community with patients and their families, and also of their ability to integrate in a team with professionals from other disciplines for the sake of comprehensive care. Mangen and Griffith (1982b) compared the follow-up given by CPNs with that of out-patient psychiatry; the results in terms of clinical state and social performance show similar improvement. Nevertheless, these results contradicted

Hunter's (1978) retrospective study which judged that intervention by CPNs was inferior to normal psychiatric follow-up. Although the findings of Mangen and Griffiths indicated a further advantage for the CPNs in terms of expressed greater satisfaction, they insisted on the necessity for imperative evaluative research to be undertaken to assist in policy formation. They realised that community psychiatric nursing had attracted very little attention from governmental bodies over the past twenty years and had failed to achieve a firm commitment within local and national policy-making.

Beard (1980) identified three organisational models of CPN services; these are:

1. Hospital-based CPNs working with multidisciplinary or intradisciplinary teams on the ward, in the day hospital, out-patient department or attached to specialist units
2. Primary health care CPNs based with general practitioners in single practices, or health centres with primary care colleagues such as health visitors or district nurses
3. Social Service-based CPNs working alongside area social work teams.

These three models exist as a result of isolated, experimental, structural development without a clear policy or scientific guideline (Mangen and Griffiths 1982a). Beard (1980) and Sladden (1979) recognised some of the existing problems with the second and third organisational models, eg the problem of overlap roles between the CPN, the social worker, health visitor, geriatric visitor and district nurse being very prominent but also

overlap in consultation and supervision by other professionals who may possess specific or specialised skills produces role rivalry and professional jealousy.

Furthermore, Sladden commented on the administrative difficulties associated with the first organisational model, ie the hospital-based model, which is not recommended in Scotland on the grounds of staff difficulties, conflicts of priority and lack of preparation for nurses to undertake community work and the argument that this model fosters dependency on the hospital.

The preference of one model over another is a very difficult question to tackle especially with the ongoing dilemma concerning the role of the CPN. Another difficulty concerns the scope of the therapeutic role of the CPN. According to Sladden an accusation was made by Marks, Connolly and Hallam (1973) that the nurse-therapists abandoned their traditional nursing role to become psychiatric technicians. Miller (1981) shares this view and criticised psychiatric nurses, viewing their role in the community as an extension of psychiatric practice, which limited their intervention to an intrapsychic-psychodynamic-developmental-psychosocial framework. On the other hand, social workers regarded nurses who extended their role into the community as expressing "dissatisfaction with their hospital role" and that they were "seeking to substitute for it the role of the community social worker". Smith (1969) gave another explanation which was that nurses failed to obtain professional autonomy. When the "Salmon Committee" (Ministry of Health and SHHD: Committee on Senior Nursing Staff Structure, 1966) dismissed the nurses' claims for professional autonomy, this promoted the conflict within the nursing role itself and with the medical profession who hold a powerful influence over

nurses' performance (Ramon, 1985).

2.4.4 Cost-Effectiveness

The most annoying problem with the CPN service, however, is the attitude towards it in terms of money and cost-effectiveness. Over the past twenty years many authorities were in great favour of the new role played by the nurse in the community, mostly because it was thought to be cheaper than keeping the patient in hospital and because it would mean the close-down of the large institutions, ie much less money needed for staffing and essential running costs (Goldberg and Jones 1980).

For instance, Mangen and colleagues (1982) compared the cost-effectiveness of community psychiatric nurses with that of outpatient psychiatric care of neurotic patients. Their findings indicated a modest cost advantage for CPN follow-up. They found support for their findings in Warren's (1971) calculations of the cost of providing CPNs for the purposes of administering depot maintenance injections. He claimed that there were substantial financial savings when compared with the alternative of in-patient care.

The cost-effectiveness of the CPN service based at Shenley Hospital, Radlett, Hertfordshire, was evaluated by Dawe (1981). Her conclusion was that the CPN service was much less expensive than keeping patients in hospital and argued that the CPN service is good value for money.

Sharpe (1985) studied the effectiveness of the CPN in relation to referred cases and found about 75% effectiveness in cases referred. On the other hand, Broadley (1985) criticised the existing community care service which has grown very fast without serious study of the most important three

parameters of need, demand and use. She clarified that epidemiological studies reveal that the shift of care for the mentally ill from hospital to community is fraught with difficulties even with short-stay psychiatric patients. It is even more difficult with long-stay patients. The close-down of large hospitals is increasingly causing great problems to those groups of patients who have spent most of their lives in institutions.

She stressed the importance of providing suitable alternatives before any attempt is to be made to shift the care into the community. She provided a good example of some hospitals, units and clinics like Barnet and Napsbury which offered a remarkable crisis intervention service and still managed to save the health authority £440,000 in 1980 for unfilled beds and only cost £45,000 to run.

Cawley (1984) in his discussion of Lord Trefgarne's report ("Developments in Community Psychiatry: A Central View") condemned the notion that community care is a convenient way of combining progress with the opportunity for economising and stressed the point that even with shortage of money, a theoretical exercise can be productive in promoting improvement.

It would seem that some writers tried to measure the value of the CPN service, including the economic aspect, to provide a basis on which the government could promote and improve the service. Nevertheless, money is not the only criterion for judgement of such a service. Carr et al (1980) gave a very good example of how mathematics can present a different picture merely because of what is included.

"It requires very little mathematics to demonstrate the cost-effectiveness of keeping 20 patients at home rather

than in a ward setting. If these people are back at home working and being visited by a CPN twice a week then this is sound economics. If these 20 people are all drawing social security, claiming rent rebates and other assorted benefits, then the economics of community care becomes less attractive."

The Richmond Fellowship Report of 1983, in stating the present situation, is critical of the governmental attitude towards mental health, as people with mental disorders get the lowest priority of care by health and social services. At the same time the government has been running down large hospitals and institutions without adequate alternative community service,

"The wide range of substitute provision, hostels, group homes, subsidised housing, domiciliary supervision, day centres, rehabilitative and sheltered workshops, has not been established on an adequate scale and the current climate, both financial and vocational, is not favourable."

Halpern (1985) reported on the message given by the House of Commons Social Service Committee to the Government about community care.

Members of the committee expressed great concern about the limited resource provided by the Government for mentally ill patients who needed constant support and help probably for the rest of their lives, eg long-stay patients and the mentally handicapped. It is also dangerous to have large numbers of mentally ill and mentally handicapped people let loose without adequate facilities or threatened to be homeless.

In support of this discussion an empirical work has been carried out by Weisbrod and colleagues (1980). Their analysis of all forms of costs of both hospital-based programmes and community-based programmes showed the former model to be "10% cheaper per patient".

On the other hand their findings showed the second model to have additional benefits and additional costs.

Their study provided two important stances for Governments and health planners to consider;

"We are mindful of the question of whether any economic cost-benefit analysis is appropriate or useful when a human service, and particularly, health is involved..... The question thereafter is not whether such analyses are desirable, for in one form or another they cannot be avoided, but how to do analyses in a comprehensive and useful manner."

It is now clear that the money problem is a basic one and should not be ignored or forgotten. The Government attitude towards running a cheaper service needs replacing and the quality of health care must be improved over a period of time by expenditure on the service. More recent is the warning given by the Social Services Committee of the House of Commons in its report on Community Care in 1985; this report is an indictment of government policies and states that "community care is not a cheap option." The Committee concludes that the drift towards care in the community has been piecemeal, inadequately funded and often carried out without any clear idea of the new requirements.

Hopefully such efforts will succeed in eliminating the ongoing rule of finding the cheapest method for keeping and treating mentally ill patients, an attitude developed in the nineteenth century and one still dominating health planners' considerations.

2.4.5 Educational Preparation

The greatest and most important problem for the CPNs is the problem of educational preparation. Nursing education is task oriented and takes a narrow focus of roles which are performed in an unsystematic and uncritical manner (Mangen and Griffith 1982a). The structure of their psychiatric nursing programme provides a serious imbalance between the small amount of academic training and the very large amount of unsupervised practice

work. This has emulated a model of general nursing and has inhibited progress towards the establishment of a role as a psychiatric nurse-therapist. Subsequently, such a background does not assist the nurse in developing a range of independent roles necessary for effective intervention in the community (Appleton 1985).

Hall and Russell (1982) criticised the educational preparation of community psychiatric nurses. They described the curriculum devised primarily for hospital nurses, the lack of relevant in-service training programmes for professional development, the absence of guiding principles to establish role identity and finally, the lack of a body of knowledge/information which nurses could use to develop their nursing skills. Miller (1981) has accused the educational system in the USA of orienting the community mental health nurses towards the role of psychotherapist and of utilising psychotherapeutic skills in the community for individuals and groups. The system does not ensure the development of nursing skills in community assessment, preventive strategies or epidemiological tools for practice in the community.

Although the new trend is to encourage psychiatric nurses to develop their skills in Behavioural therapy and Cognitive therapy (Horsfall 1983, Mangen and Griffith 1982a), yet the researcher is concerned that this might be just another fashionable trend, as behaviourism is developing so fast as to dominate psychiatric treatment; a trend similar to the former popular psychosocial model which is undergoing a period of questioning its effectiveness in how it helps patients to change their behaviour. Paykel and Griffith (1983) summarised the CPNs' qualification at present as a majority of registered mental nurses at sister/charge nurse level and a few more are state enrolled nurses. Their community training was informal,

gained through experience or in-service training. The first formal course in Community Psychiatric Nursing in Britain was an eight-week pilot venture undertaken at Chiswick Polytechnic, London, in 1970. The syllabus included psychology, sociology and social administration as well as the principles and practice of community psychiatric nursing. This course later became established and extended to one year. Similar courses have been adopted by several other centres. A national curriculum was subsequently adopted and later revised by the Joint Board of Clinical Nursing Studies (1979).

The chief course objective was

"To prepare a Registered Mental Nurse or a Registered Nurse of Mentally Sub-normal to work effectively in a multi-disciplinary team in order to give appropriate nursing care and therapeutic and habilitative or rehabilitative support to the patient in the community, taking into account his family and all relevant social aspects."

From a personal point of view, the researcher believes that nurses should not follow fashionable trends but should study and evaluate the different approaches of therapy and develop their own technique based on a client-oriented principle. Nurses have been misled throughout their historical development by the conflicts which have existed among different professions, eg psychiatrists, psychologists or sociologists, without any real gain or useful direction towards their own professionalism.

Education is linked with the quality of the output required. Skidmore and Friend (1984b) investigated the CPN practice in four different types of service: hospital-based service, primary health care based service, services with dual bases and services which originated in the community without hospital support. Forty per cent of CPNs had undertaken an English National Board (ENB) course in Community Psychiatric Nursing and thirty-six per cent had received some form of in-service training. Their research concentrated on five major areas of community psychiatric nursing:

practice; specialism; education; enrolled nurses; and ideal bases. They found that community psychiatric nursing seemed to be progressing on an ad hoc, hit-or-miss, basis with little evidence of role evaluation or intervention assessment. The research revealed that many CPNs lack effective intervention skills mainly because of inadequate education, no preparation for community work and because hospital-based training does not equip CPNs for community intervention.

Skidmore and Friend suggested changes in the present ENB courses which would introduce teaching skills, assessment methods and research models. They urged the Community Psychiatric Nurses' Association (CPNA) to take a more active role in research and education, liaising with course tutors to bring about some standardisation of training and collection of data from individuals and teams. They also discussed the need for specialisation which should be conducted with great awareness and not used to hide inadequacies. Skidmore and Friend concluded that it is the responsibility of the CPN to undertake research to find out the answers to such questions as "expansion to where?" and "training for what?"

Despite this increased awareness of the inadequacy of the educational preparation of the CPNs, yet no radical intervention for this problem has been pursued. This point is seen clearly in the Social Services Committee report on the community (1985) which urged the government to resolve the concerns expressed by CPNs at being under-trained and ill-used to work on a generic model. The report warned against the recognised waste of the CPNs' specialised psychiatric expertise, and supported the issue of CPNs receiving "direct referral" from GPs without having to go through a psychiatrist (Vousden 1985).

The above-mentioned problems are not the only identified problems; also it would be very naive to think that the solution could be found immediately without extensive research work, examination of relevant studies and learning from similar experiences. Some plans for improving the service have been suggested by different writers and organisational bodies.

Bridge, Dunn and Speight (1981) stressed the importance of developing post-basic education for psychiatric nurses in the new therapeutic approaches and that necessary funds should be arranged. Beard (1984) regarded nursing education as a training scheme to enable them to examine role and function and prepare them to be better managers of their time rather than therapists. The Joint Board of Clinical Nursing Studies course in Community Psychiatric Nursing placed emphasis on education; it would have been considerably more useful if the Joint Board had recommended ongoing training and adequate funding for this. Carr et al (1980) and Mangen and Griffith (1982a) suggested a new structure for the CPN courses. They emphasised specialisation in certain areas as it is not possible to master every skill and deliver adequate service in every field. Many areas have developed with growing problems in society, eg child and adolescent psychiatry; primary prevention; psycho-sexual counselling; alcoholism or psychogeriatric. Mangen and Griffith recommended the specialised CPNs should work alongside the General Practitioner CPN. They also encouraged CPNs to engage in research work as a means of building up a reliable theoretical structure which would help to advance their practice.

In the USA the CPNs' educational background had an advantage over CPNs in the UK: all CPNs in the USA service had at least a BSc degree and one-quarter of them had an MSc degree. However, Davis and Underwood (1976)

found that this group of CPNs were not more satisfactory because of their background as the formal education had placed more emphasis on the individual patient and was viewed in a social vacuum. Davis and Underwood recommended the provision of in-service education, particularly to cover the limitations revealed in the formal programmes.

2.5 A Review of Proposals for Modification of the Service

McKendrick (1984) questioned the logic underlying provision of CPNs from 0900 - 1730 hours Monday to Friday with the rest of the week being regarded as "out of hours". To view the perspective of extending the service to the rest of the week McKendrick conducted a survey of CPNs which revealed the need for establishing an emergency unit that could handle the caseload during the "out of hours" period.

Clark (1981), Bell (1984), and Weiner (1984) have all discussed the importance of the CPN in alleviating the increased burden falling on the GP's shoulders as the care of the elderly shifts to the community. They have also provided an example of the establishment of a successful social centre where elderly patients can go in the evenings and at weekends, equipped with modern facilities, a library and even some transport was arranged on a volunteer basis. Another example was of group homes for elderly long-stay patients (Stepney, 1985). Although they encountered many problems in terms of patient adaptation and staff preparation, on the whole it indicated the need to continue with such projects to ensure better results.

The notion of a comprehensive service and holistic approach has been stressed recently in the literature. Broadley (1985) suggested that

"Any strategy must, therefore, aim to provide a comprehensive accessible mental health service for all patients"

especially those with chronic handicap and elderly patients who find it difficult to adapt to new environments, ie the bulk of the community. Stephens (1984) described an interesting example of comprehensive community care services. It is called the "Mobile Community Treatment", known as the MCT, and was developed in 1980. It employs one part-time psychiatrist, a psychiatric resident, a psychologist, a small number of psychiatric nurses and mental health aides, an occupational therapist and a social worker. Its programme is aimed at helping chronically mentally ill patients (CMIs) who have been discharged into an environment lacking good quality community psychiatric nursing; these patients were mainly schizophrenic or with affective disorders. It was called mobile because the staff needed to be mobile, not only visiting patients in their homes or at work but also accompanying them to local shops, cinemas and so on. The MCT operated by daily contact in a natural community setting (in vivo), and used an assertive approach to actively encourage extremely passive dependent CMIs to learn basic specific skills of everyday activities. Patients could be transferred to less intensive training programmes where support and other community resources could be used appropriately to meet the changing patient needs. MCT was also concerned to teach the public about mental illness and tertiary prevention through utilisation of sheltered workshops, teaching social skills etc. Furthermore, the MCT was able to arrange for patients to find part-or full-time jobs in sheltered work, where MCT staff can liaise with employers to solve the emerging problems. The MCT were also engaged in educating the local police on how to react appropriately to disturbed individuals and how to use crisis intervention techniques. Stephens recognised the MCT as a crucial element in any attempt to construct a comprehensive service for the mentally ill.

The holistic or 'wholistic' approach to care was very much supported by Brallier (1980). He defined holistic as

"an integrated state of wellness - specifically the integration of body, mind and spirit and environment of a client."

He explained that the origin of holistic health goes back to the time of Socrates who considered the welfare of the soul was the most important aspect of living, and also to the Greeks who knew that the body could be in a diseased state because of disharmony of the mind.

In the 1960s the birth of the community mental health centres across the USA took place, while in the 1970s the holistic health clinics and practice began to take shape. Brallier hoped to see a decade of health revolution in the USA during the 1980s based on the holistic health philosophy. He listed a number of such holistic health centres in the USA, eg one in Springfield, Ohio, Westberg and Tubering. Care is provided by a staff of both professionals and volunteers; the professionals were a physician, a counsellor, a nurse, a secretary; and volunteers came from the community. Their philosophical and pragmatic focus was on the wholeness of body, mind and spirit.

The scheme was operated by accepting clients for appointment either by telephone or referral. The urgent health needs were attended to as the main concern was for overall health. A personal health inventory was filled in and reviewed by the entire staff at the initial meeting. A complete physical examination, biofeedback*, counselling service and

* Biofeedback therapy is a therapy in which delicate physiological monitoring instruments serve as teaching tools and allow clients to learn to control consciously many physiological variables previously thought to be automatic.

prevention were all carried out in the centre. Many of the chronic problems were detected early and closely followed since long-term comprehensive attention to health was provided. A wide range of holistic services would include management of special diets, therapeutic massage, acupuncture, self-healing, spiritual development, stress management and physical assessment. Patients who needed specialised skills were referred to the appropriate practitioner.

Brallier recommended psychiatric nurses holding Master's degrees as "ideal candidates" for practising within the holistic health model since they are both psychotherapists and nurses, dealing with mind and body aspects of practice with "relative ease". Also a psychiatric nurse-therapist undertaking refresher courses in physiology, medical nursing, nutrition as well as in spiritual and religious philosophies and practice, could operate within the holistic health practice. Public awareness of the holistic approach is increasing and the future trend is to make the holistic method even more public. Many of the methods used in a holistic health practice are of a self-regulatory or self-healing nature, therefore the patient has a say in his treatment and is helped to learn about his physiological and psychological responses and how to control them using such methods as biofeedback therapy.

Another model of comprehensive care was enthusiastically described by Gillespie (1982). This model was developed in the "District Services Centre" at Maudsley Hospital in London. It provides flexible care to replace the long-stay hospital in caring for the emotionally unstable patient. It has 34 in-patient places, 90 day-patient places and a drop-in policy for ex-patients.

Its flexibility lies in the wide range of services grouped under one roof and

the extended role of the psychiatric nurse. The staff consists of three teams each of nineteen workers which include three medical staff, ten nurses, three occupational therapists, two social workers and one psychologist. The staff work a two-shift system throughout the day and at night the nursing staff of the main hospital covers from 8.30 pm to 7.30 am. Nursing staff had the flexibility of working in three completely different environments: residential area; team bases; and in patients' homes.

The DSC valued the work done by patients working in three-stage, well-equipped workshops; the patients progressed through the stages on their way to recovery. The workshops could cope with various degrees of activity from light industrial to more advanced forms of industrial work. The ultimate aim of the DSC was independent living for the patients.

Wing and Olsen (1979) examined the components of community care and suggested a number of principles for each specific service eg acute/chronic patients, elderly and handicapped/retarded children, psychotic/neurotic disabled. However, they considered the principles according to whether the help needed to be given was the same whether the setting is a ward, residential school, hostel or family. According to Wing and Olsen the most fundamental principle is that there is always an interaction between clinical and social problems and it is rarely possible to separate the two for the purposes of developing independent medical and social services. Although an impairment should be distinguished from a disadvantaged/deprived person, yet it should be recognised that a combination of impairment and disadvantage would undoubtedly produce a disability. Thus "treatment" should be used to refer to methods of decreasing the severity of symptoms throughout a network of co-ordinated

sociomedical services. They explained that such a suggestion would enable people with different kinds of difficulty to advance at their own pace and to achieve a permanent settlement at the level of minimum disability. They stressed the value of experiencing success for handicapped people, therefore,

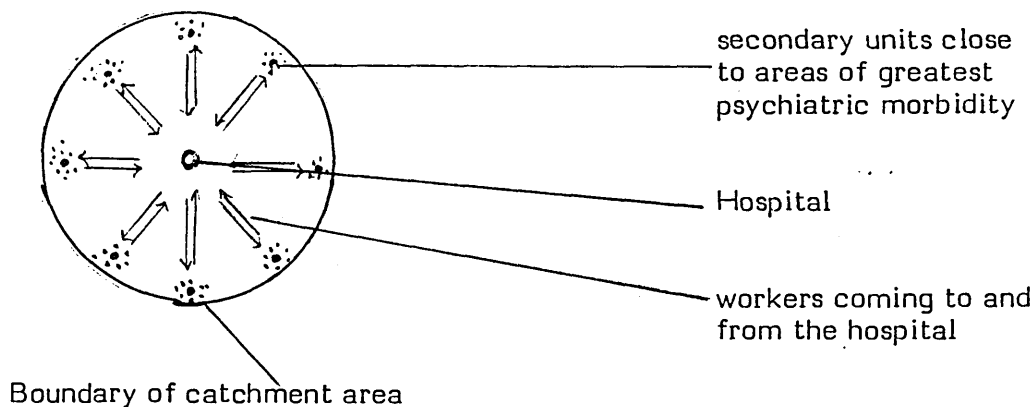
"If the highest level achievable is living within a sheltered environment, achieving this level is a form of success and not a form of failure."

From the practical point of view Wing and Olsen consider two aspects for discussion of modifications to the service: (i) units for the provision of care; and (ii) organisation of services for the disabled. With regard to the first aspect, they classified them into two forms of units - residential and occupational. The first type of units are residential settings or night units which include the hospital ward, hospital hostel, hostel, nursing home, group home (supervised), supervised lodgings, flats and bedsits and the individual's own family home. The other types of units are mainly concerned with occupational problems; they favoured day units geographically separated from the night units except in the cases of severely deteriorated patients.

The mental health nursing programme of the VNA (or Visiting Nurse Association) of Louisville in Kentucky represented a preventive model of care. Johnson (1983) described the purpose of this approach as a specific service to the "under-served client population", eg homebound elderly, chronically mentally ill, and other clients in need of outpatient treatment but unable to access available community services due to physical illness and limitations. Many benefits of this innovative programme appeared clear from the increasing number of families able to cope.

On an organisational level an interesting model of psychiatric service was suggested by Tyrer (1985) known as the "Hive System". He condemned the nineteenth century principle of deliberately setting up mental hospitals in isolated areas away from the centre of the community. He also regarded the opening of psychiatric units in district general hospitals as misplaced. He suggested, therefore, the Hive System as an ideal innovation for "true comprehensive care"

The Hive System bears a close parallel with the activities of the honey bee. In other words, the mental hospital will be the base and will be sited within easy reach of a well-defined catchment area. The psychiatric worker, like the bee, spends much of the day serving in the community but has regular contact with the base hospital so that his/her work is never carried on in isolation. These links also allow for all forms of care to be available to the worker, from simple counselling in the home to emergency hospital admission.



The Hive System of Psychiatric Care

Tyrer argued that the Hive System offered a solution to Scull's dilemma or to the problem of mental health care as identified by Professor Jones. This suggests that the Hive System has a very close resemblance to the "Bridging Therapy" theory tested in 1982.

A further attempt to develop a comprehensive model of care was the one developed by Essex and Gosling (1983). They developed an "algorithmic" method for the management of mental health problems in developing countries. They developed a flow chart to identify mental health problems and their management in those developing countries. Mental health workers were to receive training in the use of the flow chart. They divided mental health problems into eight diagnostic categories which included both psychotic and neurotic problems. The input to the flow chart is the patient's complaint or presenting problem. In line with the 1977 WHO research programme to develop and evaluate a system of identification and management of mental health problems, they set a number of goals. The following is a list of some of these goals:

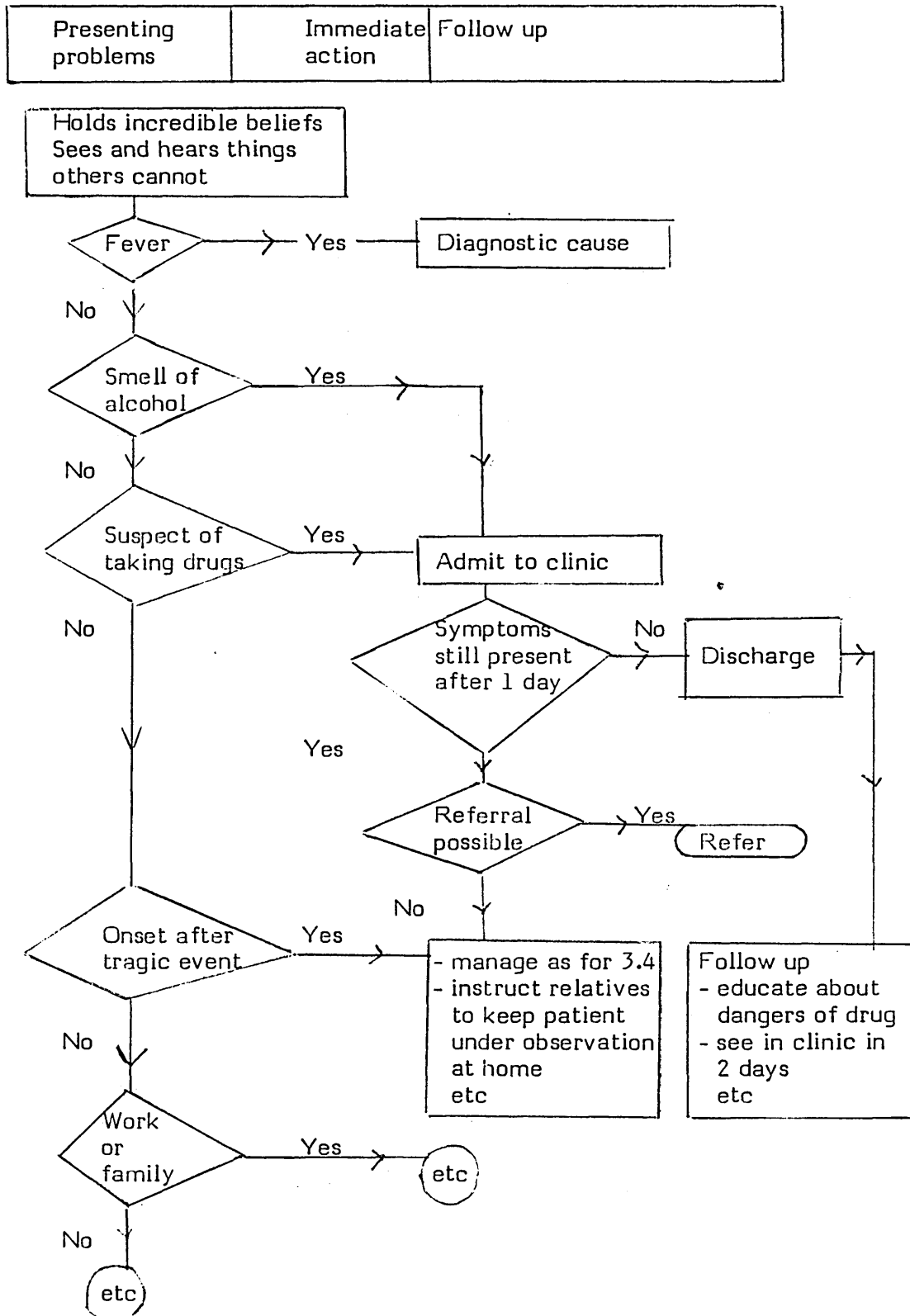
1. To be usable in many different countries
2. To be usable by intermediate level health workers in out-patient clinics
3. Must begin with the presenting problem, whether caused by physical or mental illness
4. Must indicate the most effective and appropriate management
5. Must indicate what to do when transport or drugs are not available
6. Must identify patients who need follow-up.

An example of the flow chart appears overleaf, charting the case of a patient presenting with the problem of "delusion, including hallucination".

The algorithmic approach is another interesting model of mental health care based on problem-solving skills. However, the authors admit that categorisation of mental illness is a very difficult issue among different cultures. For mental health problems, for example, they found

"... not even extensive literature reviews could identify any acceptable, feasible, appropriate, cross-cultural categories of presenting mental health problems."

The following diagram presents an example of such a chart.



An example of Algorithmic Method for Management of Mental Health Problems.

To conclude this discussion, CPNs are still in an unfortunate position; the concept of their service is still very much linked with economy and reducing costs. Scientific research to evaluate the service from the patients' point of view is still problematic. Levels of expectation regarding the scope of the CPN's role are too great for realistic achievement, especially in consideration of the lack of educational preparation, organisational policy, appropriate experience and adequate finance. Some hope for improvement of the service has been expressed by empirically planning a realistic outline of the service.

We should bear in mind that any profession is always changing to accommodate relevant new advances in science, whether technological or humanistic science. The same principle can be applied to the nursing profession; a compromise has to be achieved between the needs of the patient as an individual and as a member of society. Ideally, a comprehensive model of psychiatric care is the target goal in most of western society, so the role of the CPN as a changeable dynamic force should be moulded into a new shape based on the studies of community needs.

With regard to the second aspect, Wing stressed the importance of modifying current administrative structures which separate individual health needs from social needs. This resulted in a multiplicity of agencies, each with its own theories and methods, which do not have an integrated, comprehensive network of services.

Such a prospect is not easy to achieve and changes will not occur over night but it should start where CPNs start, ie with their educational system, curriculum content and syllabus, training models, extent of field

experience and models of examinations. A possible suggestion would be that CPNs should first train as general nurses, becoming acquainted with the different dimensions of health care (body, soul, mind and environment); then train in general psychiatric care, again in a holistic view with special emphasis on the triagram of prevention developed by Caplan (1961), plus the use of basic therapeutic skills, models of intervention, assessment techniques and research methods for problem-solving purposes. Nurses who seek further specialisation could join more specialised courses attached to certain school(s) of therapy. On the other hand, from an organisational point of view, but again one leading towards comprehensive care, CPNs are members of a multi-disciplinary team which provides its service at all levels of the different settings, ie district hospital in/out patient, health centres, residential homes, or patients' homes. With such a comprehensive task the system of inter-communication between different disciplines and various catchment areas should be developed and used to set maximum efficiency as it is the most important element in providing comprehensive care. The system of referral should be adequately used, and patients' specific needs should be referred to the team member who is the most qualified to meet such needs.

It is essential first to set up rules and a policy to regulate and promote the dynamics of the service. Maximum support should be provided to team members, including the nurses, without discrimination. Such a policy would help the nurse to push forward and proceed towards social and political influence which has been handicapped in the past by the power of other professions. Nurses with a BSc or higher qualification are equivalent to members from other professions such as physicians or psychologists with BSc or higher qualifications. It is no longer applicable or acceptable to force role tasks on nurses who must now learn to decide for themselves

the nature of their role which should not be in isolation from the needs of society or from modern developments.

Nurses should formulate their theoretical bases and feel free to adopt as much as they need from the various relevant sciences with an intelligent awareness of its direct and indirect practicality, eg computer courses, administrative skills and problem-solving approaches.

CHAPTER 3: MODELS OF THERAPEUTIC INTERVENTION

- 3.1 Introduction
- 3.2 Three Relevant Psychotherapeutic Approaches
 - 3.2.1 Thorne's Eclectic System
 - 3.2.2 Reality Therapy
 - 3.2.3 Supportive Psychotherapy
- 3.3 The Flexible Integrative Approach (FIA)
- 3.4 Classification of the Main Therapeutic Models
 - 3.4.1 Psychoanalytic
 - 3.4.2 Humanist-Existential
 - 3.4.3 Perceptual-Phenomenological
 - 3.4.4 The Rational Approach
 - 3.4.5 The Behavioural
 - 3.4.6 Biological Model
 - 3.4.7 Social Model
 - 3.4.8 Group Therapy
- 3.5 Practical Implementation and Limitations of FIA - Psychotherapeutic
- 3.6 Practical Implementation of FIA - Nursing Process
- 3.7 Conclusions

CHAPTER 3: MODELS OF THERAPEUTIC INTERVENTION

3.1 Introduction

The term "psychotherapy" is not confined to a single set of procedures or techniques, but includes a wide variety of therapeutic approaches, as will appear from the following discussion.

Currently there are many treatment systems, over two hundred and fifty, based on widely differing theoretical constructs, yet they do not offer a simple explanation of what 'psychotherapy' is (Bloch 1982). Bloch's investigation of the different definitions given to psychotherapy indicated that most therapists, apart from Szasz and his colleagues, have viewed psychotherapy as

"a relationship between a helper and helpee where the expert gives intentionally support and guidance to the one in trouble."

The helper here should be committed to that role and be recognised socially as a healer. Such a view was not compatible with Szasz's concept of psychotherapy in which he argues that

"Psychotherapy refers to what two or more people do with, for and to each other, by means of verbal, non-verbal messages. In short, a relationship comparable to friendship, marriage, religious observance, advertising or teaching."

Smail (1978) has a third view of psychotherapy. He claimed that there is no such thing as psychotherapy, but rather it is an attitude adopted by people who are reluctant to take decisions for themselves and who recognise other people, such as priests, gurus, doctors, as possessing powers and abilities which are more advanced than their own, consequently

those in power begin to act as experts in human nature.

This situation resulted in ideological battles that have been waged over the last three decades, leading to an increase in the mystique surrounding psychotherapy which still appears to exist.

Nevertheless, a considerable number of significant attempts to uncover the myth of Psychotherapy have been made by the initiative of certain scientists whose efforts explained a great deal of the mystique of the nature of human behaviour. Despite the fact that these attempts have increased the number of conflicting theories, yet they all share a common ground, ie the relationship between patient and therapist. This relationship should be beneficial to the patient, who sees the therapist as powerful, skilful and to be trusted to carry out successful therapy which would remove the patient from his diseased condition. No matter what type of treatment the therapist uses, therefore, the fact remains that the helper has the skill to be of help to the patient. This fortunate feature of psychotherapy, however, was not sufficiently regarded by Truax and Carkhuff (1967) who noted that the existence of many alternative theories in the field of psychotherapy implies that none of them is completely adequate for the task of therapy.

"The great proliferation of theories of counselling and psychotherapy reflects more and more clearly the inability of any one existing theory to prove itself universally correct and useful in prediction and practice."

On the other hand this negative phenomenon had played a positive part in developing our awareness of the limitations of current theories. Generally, research was active in helping with the selection of superior procedures and the elimination of parochial ones. Several clinical experiments were undertaken to find out the elements which favoured one particular

approach and not another. Yet another different dimension was found to be a very important aspect for successful therapy to take place; this is the patient's personality. Crown (1984) presented a careful examination of some clinical experiments which proved that the results of therapy were very much determined by the patient's antecedent personality make-up.

"The successfully-treated patient was reasonably mature, competent and assertive, he had relatively specific difficulties and was highly motivated for help and willing to work towards a solution of his problems."

One would argue with Crown that such characteristics would exempt his patients from the group called "mentally ill"; another argument could be based on Szasz's definition of psychotherapy which would recommend that such "patients" are only in need of a secure consistent relationship, provided by a friend or through marriage, but not necessarily by therapy as such. The term "mental illness" per se is also another problem which opens up the field for endless argument.

To examine this problem and its significance to the current study, a review of a number of psychotherapy approaches will be presented in this chapter. These were selected for two reasons: first, for their direct relevance to the formulated approach which was developed by the researcher to be used in this study, and which was given the name "Flexible Integrative Approach", (FIA); second, because of their particular importance as origins for most of the approaches currently used in today's practice.

Certain classifications were developed by many writers in order to group the different schools under defined categories which would represent the common features of these theories. Bloch (1982) classified most of the

theories under three main schools: the psychodynamic, the behavioural and the existential schools. Burgess's (1981) classification was a little different as she recognised the importance of including social and biological models of care. These categories will be discussed at a later stage in this chapter.

Patterson (1980) produced a slightly different classification of schools of therapy from that of Burgess. It included the rational and phenomenological approaches. He also discussed a completely different approach which was not to be grouped with any of the developed categories of classification because of its unique nature. This approach is the eclectic system, which was found to be the most relevant psychotherapeutic approach and the most suitable for the current study.

The other two approaches which formed the basis of the FIA were 'reality therapy' by William Glasser in the 1950s and supportive psychotherapy which is an integral part of the psychodynamic schools of psychotherapy. The main characteristics of these three approaches and their relevance to the FIA will now follow.

3.2 Three Relevant Psychotherapeutic Approaches

3.2.1 Thorne's Eclectic System

Eclecticism in counselling refers to selecting, picking out or choosing from various systems or theories, presumably selecting the best from each but there is no criterion for deciding what is the best. The choice is an individual one and everything depends on the circumstances of the client and the counsellor.

The eclectic system was developed by Frederick Charles Thorne (1909-1978) as an attempt

"to collect and integrate all known methods of personality counselling and psychotherapy into an eclectic system which might form the basis of standardised practice."

(Thorne, 1961)

Patterson stated that this approach has been subjected to extensive criticism by many writers who hold a particular school of thought; eg by Rogers (1956) who described it as "superficial", "confused" and that it "has blocked scientific progress in the field of psychotherapy"; and by Snugg and Combs (1949) who wrote that

"An eclectic system leads directly to inconsistency and contradiction, for techniques derived from conflicting frames of reference are bound to be conflicting."

On the other hand, Thorne (1967) has defended his eclectic approach by arguing that all of the major theories or approaches are incomplete and attempts to incorporate them into an all-inclusive method utilising

"the contributions of all recognised systems and schools of psychology according to their indications and contraindications."

His integrative psychology is a systematic theoretical foundation for eclectic clinical practice. Beutler (1983) supported eclecticism but rejected such attempts to

"choose bits and pieces from a wide spectrum of counselling theories and methods"

resulting in a

"hodgepodge of contradictory assumptions and incompatible techniques."

Instead he proposed an "emerging eclecticism" developed from research and experience that reveals common parameters of counselling derived from a comprehensive study of all theoretical positions. His objective was to develop eventually a comprehensive, consistent and systematic synthesis. Thus, this newer concept of eclecticism is not atheoretical. The "eclectic stance", as described by Truax and Carkhuff (1967) is systematic but open, based on the

"recognition that no one theoretical orientation or series of techniques is adequate to deal with the complexities of multiple persons in potentially constructive interactions."

Therefore eclecticism is a systematic, integrative, theoretical position. Eclecticism in counselling was recognised by Thorne as early as 1945, but no members of the Division of Clinical Psychology of the British Psychological Society identified themselves as eclectic; by 1970 over 50% so identified themselves. This was impressive evidence of the change in attitude towards the eclectic position (Patterson, 1980).

Thorne (1967) described his approach as "rigidly scientific and eclectic". It is inductive rather than deductive.

"Instead of starting with theoretical preconceptions and then checking the fit of facts to the model, the eclectic usually proceeds inductively, gathering and analysing the data and only later attempting to construct explanatory theories. The main problem in all clinical work is to discover the organisational dynamics of the person under study rather than to invent one out of possible theories."

A Clinical Eclectic Viewpoint of Personality

The concept of "personality" has been replaced in Thorne's system by

"person" or "behaviour". He presents his point of view, or system, in 97 postulates. The core of this view regards personality as consisting of changing states of the total, or whole, individual living organism as it copes with the experience of interacting with its environment in unique, individual ways that differentiate it personally and socially from others. Thus the person is perceived on the basis of entering into the world and experiencing it through the utilisation of the existential-phenomenological method.

Personality dynamics involve a series of drives: firstly, a drive for higher organisation which includes a person's needs to maximise himself/herself to achieve perfect functioning, organising and expanding experience into meaningful wholes. Secondly, they involve a drive to achieve and maintain stability of organisation; this includes self-preservation, homeostasis, habit system, ideological controls, life goals and purposes, role and status, and life style. The third drive is the drive to integrate opposing functions in order to resolve imbalance but not necessarily to avoid tension.

Consciousness is the central datum of psychology and conscious experiences are "primary behaviour data whose existential reality cannot be denied." Consciousness functions as a master sense organ which is the main organising, integrating and unifying unit mechanism determining and making possible higher level personality functioning. The contents of consciousness determine mental status and its disturbance results in disturbed behaviour. The non-conscious aspects of behaviour are only postulated when hypotheses concerning normal conscious mental life have been exhausted.

The "self image" or self concept is what one thinks of oneself to be, particularly as we think it appears to others. The ego functions include an awareness of itself, evaluation of itself, regard for itself and control of itself. Accumulation of self knowledge constitutes the core of "self-perception mass".

Thorne (1961) regarded personality as evolving in an irreversible sequence of statuses in the process of becoming "self-actualised". More important than personality traits are the ongoing acts of the individual in terms of existential concept through the transcending of his past and present existence to shape his future.

"The ultimate value of man, both personally and socially, is a function of the quality of his cognitive functioning."

Personality development is influenced by constitutional biological factors, cultural factors, and self-actualisation. The drive for self-actualisation is one of the most powerful human motives and involves a dissatisfaction with self and a working toward self-improvement or perfection plus the awareness of alternatives and the existence of decision-making.

"From the eclectic viewpoint, personality development is regarded as a struggle to transcend affective, impulsive unconscious determination of behaviour by learning and perfecting rational-logical-voluntary control of behaviour."

Thorne decided to formulate an etiological equation derived from different schools, in order to identify disturbing factors in the patient's personality or his environment thus affecting the treatment plan.

The Etiological Equation

Thorne's (1968) equation is based upon the diagnosis and provides the basis

for treatment. It

"differentiates between primary, secondary, predisposing, precipitating, pre-existing and situational factors and attempts to weigh the contribution of each."

Twelve classes of etiological equations are identified in terms of prepotent determining factors:

- (1) biogenetic determination,
- (2) constitutional determination,
- (3) pathological physiological determination,
- (4) affective or emotional conflict determination,
- (5) cognitive-behaviour determination,
- (6) conditional mental context determination,
- (7) role playing and social status determination,
- (8) self concept and ego structure determination,
- (9) life style determination,
- (10) interpersonal-transitional determination,
- (11) existential-status determination, and
- (12) social-environment determination.

Characteristic etiological equations are given in each class. An example of equations under (8) are as follows:

- a) low self-concept + lack of confidence = poor performance = inferiority complex (Adler)
- b) low self-concept + anxiety over failure = defensive reaction formations = existential anxiety etc.

Direct examination is necessary to determine etiological equations; psychological tests are not adapted to the measurement of changing

psychological states and are not available to measure factors in the higher level integrations.

"Clinical judgement is the only tool available for differentiating, evaluating and weighing all the various classes of factors etiologic to psychological condition."

Therefore the clinical encounter is a basic factor for sensitive, accurate clinical judgement. Thorne described the clinical encounter thus:

"In the existential sense, every interview should be a genuine clinical encounter in which clinician and client experience each other and themselves more completely and meaningfully. Factors like personal warmth and liking, unconditional positive regard, non-judgmentalism, non-imposition, permissiveness, empathy and genuineness are important to reduce defensiveness and provide a safe environment in which the client can be and experience himself/herself more completely and constructively."

Terminating Case Handling

The closing phase of counselling is characterised by the achievement of an understanding of the nature and origin of the maladjustment, the reduction in tension and defensive reactions and the development of a rational approach to dealing with maladjustments or problems. The client is freed from affective-impulse behaviour and is able to use intellectual resources in problem-solving behaviour. With clients of lower intelligence, counselling may continue with the counsellor contributing more actively or directly to the solution of problems.

To summarise, Thorne appears to select a single - and what he considers the major - problem and work on that, apparently moving on to other problems later. The etiological equation is to be the basis of treatment and is unique to each client being constantly revised, almost on a moment-to-moment basis. Thorne's practice is highly didactic or tutorial; the

general approach is a rational, logical problem-solving approach. Thorne's approach incorporates basic common elements of all systems or approaches; these are the three major elements or "core conditions" . These are empathic understanding, respect and warmth, and genuineness. Thorne places emphasis upon self-actualisation, self-enhancement and self-consistency as the primary dynamic motives underlying all of life and at its highest level of integration which agrees with the perceptual phenomenological existential system and the Gestalt approach. This provides an organising principle which is necessary for a truly integrative system.

After the eclectic position of Thorne comes the more recent work of William Glasser, in 1975, who placed particular emphasis on the patient's responsibility towards himself. This approach is known as "reality therapy".

3.2.2 Reality Therapy

Reality therapy is a well-established school of therapy developed in the 1950s by William Glasser (1975). Its basic theory recognises that people develop an identity image by the age of 4-5 years and come to view themselves as either a failure or a success. To develop a successful identity each individual must meet two basic psychological needs:

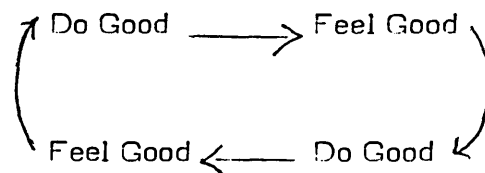
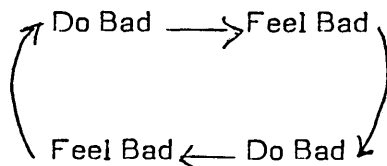
- (i) know that at least one person loves him and in return love at least one person, and
- (ii) view himself as worthwhile and that at least one person sees him as worthwhile (Ellis 1984).

Additional work done by Glasser and Zunin in 1973 emphasises the importance of "responsible behaviour" (Colvin 1980). Glasser viewed

mental illness as a form of "irresponsible behaviour". An individual's attempt either to deny reality or to ignore it protects that individual from facing feelings of worthlessness, meaninglessness or insignificance in the world, but this is a sign of "mental illness" or "irresponsible behaviour". (This excludes mental illness of a biological origin.)

His process of reality therapy consists of six steps that must be completed and followed, in the sequence described below:

1. Involvement: It is extremely important and difficult and requires major skill to build a confident relationship between the therapist and the client. Transference is not encouraged, instead there must be warm understanding and sincere interest in helping the person towards more responsible behaviour. The relationship should be built on honesty and clear understanding on both sides.
2. Examining current behaviour: Here the focus is on the client's present behaviour, regardless of past life experiences. Past life events, no matter how traumatic, are not accepted as an excuse for irresponsible behaviour, as behaviour is considered far more important than feelings. Therefore the therapist must concentrate on what the client is doing rather than what he is feeling:



3. Make value judgements: The client is guided to evaluate his behaviour and make value judgements about his behaviour. The client must see

that his current behaviour is not working to his advantage and decide that he needs to make some changes. Such procedures are often painful, support and assistance should be given, but one must never tell someone how to live their life.

4. Making a plan: The client is helped to make a plan to change his behaviour. The client's motivation and abilities should be carefully considered, ie must be neither too complicated nor overly simplistic. The plan becomes a written contract that includes details of activities, time, place etc.
5. Commitment to the plan: The client is asked to make a commitment to the plan. No plan can work if the client does not make such a commitment to carry it out. Commitments are generally difficult for clients who suffer an identity of failure. The therapist monitors the commitment to determine whether it is realistic and suitable for implementation.
6. Alter the plan if necessary: The therapist does not spend time dwelling on a failed plan and making excuses as to why the client did not keep the commitment, or blaming him for its failure. The goal would be to look at the present and determine whether the client is going to fulfil the old commitment or whether to make a new plan. No form of punishment is used as punishment reinforces a failure identity.

Supportive psychotherapy is perceived as the basic element for all psychotherapeutic approaches, even with those techniques which need hostile/aggressive intervention, eg some forms of behaviour therapy or psychoanalytical exposition. Therefore implementation of supportive

psychotherapy was fundamental to the developed approach.

3.2.3 Supportive Psychotherapy

The term "Supportive Psychotherapy" is commonly used, (Crown, 1984) yet it is conceptualised in different ways. Technically, Bloch (1984) defined it according to the direct meaning of the word (from Union 1979 dictionary),

"supportive, sup = sub + portare = to carry"

He explained that the word means to "hold up" or "lend a hand" which is the main therapist's task towards his patient.

Supportive psychotherapy aims at restoration of the patient to his former state to enable him to achieve once again a state of psychological equilibrium. It is not intended to cause radical changes in the patient's life or personality, therefore great care is taken not to disrupt reasonable defences, the generation of conflict is avoided and critical feedback to the patient is kept to a minimum. According to Crown (1984), the process of supportive psychotherapy relies heavily on a number of factors, the most important being:

1. The relationship that develops between the therapist and the patient. This, to a great extent, resembles the relationship between parent and child. It provides security, shelter, warmth, acceptance, understanding and willingness to help. This relationship encourages total or partial dependency on the premise that the effects of stress have rendered him unfit to sustain his independence.

2. In addition to this relationship, various therapeutic techniques, such as active listening, explanation, advice, encouragement, helping the patient to express openly his suppressed problems or feelings, and environmental manipulation, eg his job or accommodation, are important factors to be included.
3. The treatment programme is designed according to the patient's needs and capacities. It is useful to have a form of written contract agreed by both the patient and the therapist.

The previous elements of the supportive psychotherapy process are flexibly shaped according to the type of the patient. Bloch (1982) described two types of patient groups who might benefit from this therapy.

1. Patients in crisis: those experiencing stressful circumstances that proved too much for their coping abilities. Yet their personality is well-integrated and what they need is a breathing space, alleviation of the distress and to receive guidance and learn a better adaptive mechanism. Usually the issue here is crisis intervention and the plan, in most cases, is for a period of weeks.
2. Chronically handicapped patients: usually these are patients handicapped by enduring conditions such as some form of schizophrenia. Treatment is geared towards the provision of support on a regular continuing basis for several years.

Other helping agencies are important to include in the therapy, eg community day centres, day hospitals, occupational therapy workshops etc. It is also important to form a helping team, made up of GPs,

psychiatrists, psychologists, social workers, nurses, family members and fellow-patients to ensure comprehensive support and to decrease the caseload for the therapist.

The preceding review of three theories of psychotherapy serves mainly to provide an explanation of the ideology of the developed approach FAI; nevertheless these three theories were not complete and have some weaknesses. For instance, with the eclectic position, Thorne's system consists essentially of assumptions and opinions rather than the integration of empirical facts and validated knowledge. But this problem may be solved with further testing and evaluation, or modification of the assumption. Thorne would, no doubt, agree that his approach is only a first approximation towards a more definitive eclectic system.

In reality therapy, some conflict is recognised within the theory itself; eg it refuses to dwell on the patient's past, but at the same time emphasises the importance of personality development. This inner conflict within this theory may have originated as a result of employing some conflicting principles from the existential, behavioural and psychological viewpoints without establishing a connecting link to integrate them. An integration of some of the phenomenological or perceptual techniques could be useful in this case, ie the therapist's concern is not only to help the patient to take responsibility towards his own life but also to help the patient improve his perception of different phenomena.

The major problem with supportive psychotherapy is dependency. This form of therapy encourages dependency at the early stages of treatment, hoping that the patient gradually will be able to relinquish his dependency. On many occasions the patient would sample the advantage of dependency

and develop an inclination to become overly dependent. On other occasions the therapist would encourage dependence and gain satisfaction from such a process. This phenomenon is quite dangerous and could jeopardise the therapeutic effect.

Awareness of this problem should be brought to the surface and discussed quite openly between the therapist and the patient. A contract, either formal or informal, could help to set limits to such an attitude. This problem can be reasonably avoided in the rational-emotive therapy which will be discussed later in this chapter.

3.3 The Flexible Integrative Approach (FIA)

The approach formulated was quite comprehensive as an attempt to find a basis for a flexible routine of work that could incorporate principles from some different approaches both from a psychotherapeutic and a nursing point of view.

The approach, formulated by the researcher and labelled the Flexible Integrative Approach (FIA), did not favour one school of therapy over any other, but it used the appropriate principle for the appropriate situation for a particular patient at a particular time. To be able to know what is appropriate all the time is a debatable point. However, shared opinion, scientific procedures of problem-solving, consideration of the patient's viewpoint and the employment of systematic procedures, could be means for eliminating bias or unexpected side-effects and could lead to improved decision-making for more effective intervention (Bennett, 1978).

The previous review of some of the theories of psychotherapy has implied that the problem with psychotherapy is that the different models continue

to vie with one another without success in finding one adequate answer to the question 'What is the best model for psychotherapy?'

Nevertheless, these approaches proved useful in developing a conceptual basis for the therapeutic process with a considerable scientific orientation. It would have been ideal to find enough consistent data that could be generalised and used successfully with different patients showing different forms of illness. Yet it is important to note that variations in the interpretation of the origins of neurosis and psychosis are positive signs that psychotherapy is dynamically heading in the right direction and not static in pursuing empirical evaluation (ie seeking a simple explanation of the marked variations in human behaviour, personality and perception or intellectualisation). However, each individual is unique and so, therefore, is each therapeutic process. The explanations produced by the different schools of therapy are useful to facilitate the investigation of the psychological problem; yet the process tends to become purely personal, shaped by the therapist, the client and the environment. Smail (1978) recognised this phenomenon and demonstrated that what a therapist might say does not necessarily match what actually happens in therapy. Furthermore, he added that although those theories can

"have consequences for our view of ourselves and our relations with each other, yet they often are not put into therapeutic practice."

For this reason educating or training a person in 'psychotherapy' is not enough because it would result in

"a) creation of 'experts', semi-experts or technological agents who promulgate theories or apply therapeutic techniques with very little critical understanding of the dubious nature of their conceptual foundations; and

- b) reinforce a cultural attitude in which, in matters with which they are not acquainted at first hand, people simply accept what they find."

The therapeutic approach (FIA) used in the current piece of work was basically eclectic in nature. It did not adhere strongly to one approach in particular, but it was closely correlated with the principles of a number of approaches that appeared particularly relevant to the techniques developed by the researcher. Therefore in that sense it was a personal approach. Two reasons dictated this trend: firstly, the unsettled state for favouring one approach rather than another; and secondly, the difficulty in gaining adequate experience in the practice of each type of approach. There was nothing new about the main shape of the FIA, apart from its flexibility in shifting the emphasis of the therapy from one point to another according to the patient's needs. By means of this process different principles from different schools were used to cope with the many dimensions of each presented problem.

Although the main ideological shape of the FIA was formed from Thorne's eclectic theory, Glasser's 'reality therapy' theory and Crown's (1984) supportive psychotherapy model, yet other original schools of therapy also had a relevant impact.

These original schools were: the Psychoanalytic School, the Humanist-Existential School, the Perceptual-Phenomenological Approaches, the Rational Approaches, the Behavioural Schools, the Biological Model of Care, the Social Model and Group Therapy Model. The following discussion will briefly include the entities of these schools and their impact on the FIA.

3.4 Classification of the Main Therapeutic Models

It is of importance here to provide a brief summary of some of the major therapeutic models because of their originality and crucial influence on the approach developed in the study.

3.4.1 Psychoanalytic

The Psychoanalytic school includes mainly Freud's work as the source of its basic concepts. Some authors, like Burgess (1981) and Brown and Pedder (1979), called it the psychodynamic school to include some of the other theories that emerged and separated from the orthodox approach. Talking cure through catharsis of feelings is the basic technique of this school, aimed at freeing the conflicting forces and exploration of the unconscious. Freud, through his knowledge of the central nervous system, was able to recognise that higher centres of control can inhibit primitive ones (Brown and Pedder, 1979). Similarly, he developed the theory of the level of consciousness and the structure of personality. He recognised the problem of anxiety as the origin of neurosis, including depression.

Freud also recognised motivational drives as important forces and central for both the psyche and soma. The psychosexual development phases were central issues in his theory, which raised considerable disagreement among the psychosocial and existential schools.

Transference was of specific importance in his therapeutic relationship and became a tool for investigating the forgotten repressed past. On the other hand, he recognised the problem of "counter-transference" and advised the therapist to go through a purification process first. A further contribution made was the use of interpretation of dreams to function as "the road to a knowledge of the unconscious".

3.4.2 Humanist - Existential

This school started mainly as an opposing reaction to the materialistic approach to the study of human behaviour by Freud and his insistence on instinct-based and unconscious determinism. It was begun originally in Germany and Switzerland in the beginning of this century by a number of pioneers like Binswanger, Boss and Frankl. According to Bloch (1982) they adopted a religious approach, derived from existential philosophy, that every human being is (a) the author of his own world; and (b) that his knowledge of the world can only be achieved through his experience of it by his consciousness.

Viktor Frankl (1967) developed the "Logotherapy" theory which incorporated two important concepts of Freedom and Responsibility, to choose to live authentically or unauthentically. According to the existential school, the origin of neurosis is the fear of death, and the avoidance of facing the "Angel" or the "existential anxiety". Existential psychotherapy is concerned with the patient's present and future. The treatment involves making the patient responsible for himself in seeking to change his way of life.

A good example here for such an approach is the client-centred therapy developed by Carl Rogers (1951). Rogers recognised the conflict between freedom and determination. He hypothesises that human beings are rational, socialised, constructive and forward-moving; and that each individual has the potential for growth and self-actualisation. The maladjusted disturbed individual is characterised by incongruence between the self and threatening experience. The individual reacts defensively, denying or distorting experiences. Therapy is directed towards helping the individual to become more congruent, less defensive, more realistic

and objective in his/her perception, more effective in problem-solving and more accepting of others.

The most important feature of Rogers's therapy was the move from talk to action and the emphasis on expression rather than on understanding, and the engagement of the client in a series of technical exercises to loosen conscious resistance, to develop self-awareness and change. Nevertheless, his approach did not help to resolve the conflict between freedom and determination in the existential theory.

3.4.3 Perceptual - Phenomenological

De Koning (1982) tried to explain the philosophy of Phenomenology and strove for an adequate definition:

"Phenomenology is an attempt to re-establish contact with this world in which we live and to re-appropriate that which has been lost. . . . The task of the phenomenologist is to go to the 'things themselves', as they are 'in themselves' and to describe them and our immediate experience of them. . . . Phenomenology is an attempt not only to understand the 'lived world' but also to understand it better by being critical of assertions made with a naive attitude and to remove presuppositions."

He explained that phenomenology is also a philosophy that puts essence back into its existence through the understanding of its concreteness, not only its absolute measure. Therefore essence, here, is always related to the experience of the world by the individual and its meaning for him/her. In this respect the reflection is neutral and is employed in the phenomenological analysis as an attempt at understanding what the phenomena mean.

A specific example of this approach is Kelly's psychology of personal constructs and counselling in 1955. His theory of personal constructs is

based upon the philosophical position of constructive alternativism by which a person has many workable ways in which to construe the world (Kelly, 1955). The system is developed on the basis of a single postulate and its elaboration by means of 11 corollaries. This basic assumption is that "a person's" processes are psychologically channelled by the ways in which he anticipates events. Therefore, the individual's system of personal constructs determines the way the world is constructed. These constructs have certain formal characteristics that form a hierarchy of subsystems of diagnostic constructs. The therapist's task here is to analyse, understand and subsume the client's construct system. Therapy is directed towards change in behaviour and reconstruction of the personal construct system. The process of therapy is similar to the process of scientific experimentation. The therapist helps the client to develop hypotheses and test them experimentally, both within and outside the therapeutic session. The therapist, in this model, should be highly active, manipulative, constantly prodding, pushing and stimulating the patient. Such an active nature of therapy places tremendous responsibility on the therapist and creates the need for decision-making and continuous evaluation and judgement. The purpose of this technique is to get the client to believe that the therapist is in control and that the 'doctor knows best'. Yet Kelly recognises the dangers of this method and warned against the therapist playing God.

Although Kelly's approach is considered one of the most systematic, using rational, intellectual and cognitive features, and is highly sensitive to various possible forms of client behaviour, yet it lacks an actual therapy protocol and diagnostic techniques. Another limitation in Kelly's approach is the lack of a concept of 'motivation' or 'need'; however his basic postulate does have a motivational aspect including a goal or direction for

all behaviour. Despite these problems the personal construct theory is considered by Bruner (1956) as

"the single greatest contribution of the past decade to the theory of personality function."

3.4.4 The Rational Approach

Rational theories of counselling or psychotherapy are those that tend to take a logical, intellectual approach to the process and to the solution of the client's problems. They tend to be simple in nature, but also eclectic, ie adopt a variety of therapeutic techniques on the basis of common sense or empiricism. Rational approaches are usually based on an analogy between medicine and counselling/psychotherapy; thus they place great emphasis upon diagnosis and differential treatment. A good example of this approach is Williamson's approach in 1950 which has become known as the "Minnesota point of view". It is based on the perception of counselling or psychotherapy known as "Education".

Accordingly the basic purpose of education here is not only to train the intellect but also to assist the individuals (students) to achieve emotional maturity within the range of their potentialities, ie counselling joined with instruction. Its standpoint is that through education the client will learn how to understand himself and use intelligence or rationality to change or correct his responses in order to achieve a rational, satisfying life. Because the development was originally in an educational setting the counsellor is essentially a teacher with the curriculum being clients and their own style of living.

Therefore, the concept of counselling in this context involves the application of science, objectives, facts or knowledge to the problems of the individual in order to help him/her to make the best choices or

develop a system of values, without pressure on the client or denial of the right to self-determination. Counselling does not end with the resolution of the affective elements present, but extends to a rational problem-solving approach to the specific problems that troubled the client. Williamson and Darley (1937) listed six steps in the clinical counselling process: analysis, synthesis, diagnosis, prognosis, counselling and follow-up.

The Minnesota point of view, in brief, is an attempt to apply a scientific approach to counselling by the use of measurement and prediction. The process consists of gathering objective data about the client, synthesising the data into a diagnosis, predicting outcomes (prognosis) and planning a programme of action derived from these data. While the emphasis is upon the rational process in problem solving, the influence of emotions is not ignored. However this approach has the limitation of the emphasis placed on obtaining "objective data" and measurements which are quite doubtful. This emphasis had a narrowing effect on this approach as it did not adequately consider the affective reactions of clients nor the clients' own perception of themselves and the world. Another recognised limitation is the lack of a systematic approach to counselling. It is characterised by being highly individualised with no criteria given for the use of specific techniques. On the whole, the Minnesota point of view is one of the most complicated, intellectual approaches.

Another useful example of the rational approach is the Rational-Emotive Therapy (RET) developed by Albert Ellis in 1962. It was considered by Patterson (1980) as

"The most extreme of attempts to introduce logic and reason to counselling or psychotherapy."

Ellis (1962) claims no originality for the concepts that make up his system but viewed them as already formulated by many ancient and modern philosophers, psychologists, psychotherapists and social thinkers. RET makes certain assumptions about the nature of human beings and the genesis of their unhappiness or emotional disturbance:

1. Human beings are uniquely rational, as well as irrational. Rational thinking results in effective, happy and competent individuals.
2. Emotional psychological disturbance - neurotic behaviour - is the result of irrational and illogical thinking. Emotion accompanies thinking and thinking is, in effect, usually biased, prejudiced, highly personalised and irrational.
3. Irrational thinking originates in early illogical learning. Human beings are biologically predisposed towards irrational thinking and environmental conditions and experiences build upon this predisposition. Psychotics have stronger predispositions towards disturbed thinking.
4. Thinking accompanies emotion and emotional disturbances, irrational thinking persists if the emotional disturbances persist as a result of internal verbalisation.
5. Continuing states of emotional disturbance which are a result of self verbalisation are determined not by external circumstances but by the person's perception and attitudes.
6. Negative and self-defeating thoughts and emotions must be attacked

by a recognition of the person's perception so that thinking becomes logical and rational.

Ellis (1962) pointed out eleven fallacious ideas that are almost universal and their acceptance leads to emotional disturbance or neurosis. A person who believes in them will eventually become inhibited, hostile, defensive, guilty, ineffective, inert, uncontrolled, unhappy and emotionally upset.

RET recognises the individual's ability to determine his/her own behaviour and emotional experience. It adopts the ABC theory of behaviour and personality disturbance. A is the Activating Event or Experience, B is the individual Belief System and C is the Consequence. A is not the direct cause of C but is actually the result of B. If B is realistic Belief (rB), the Consequence will be rational Consequence (rC). But if B is illogical Belief (iB) then the consequence will be irrational thinking (iC). The person's response to the Activating events (A) will depend upon how the individual perceives and interprets A. Therapy consists of attacking irrational Beliefs (iB) by Disputing (D) them. The result is cognitive Effect (cE) and usually a behavioural Effect (bE). As a result the client's (iBs) become (rBs) and the (iCs) become (rCs). RET may be either for a short or long-term, ideally for two years. It is for individual or group therapy or combined. Although RET is a logical-rational approach, yet it has some weaknesses that could limit its effectiveness. Ellis claimed (1977) that this approach had a 90% success rate, but by success he did not mean cure but rather improvement.

One could argue about what "effective " means in Ellis's belief; and whether such a directive approach might not lead to patient dependency. His approach resembles brain-washing, as he places great emphasis upon

persuasion, suggestion and repetition. On the other hand, Ellis's direct methods and argument are not necessarily effective methods for changing attitudes and behaviour but instead may lead to resistance.

3.4.5 The Behavioural

This school is completely the opposite of the psychodynamic, existential and phenomenological schools. Its basic theory is that all human behaviour is learned by certain processes, either through classical conditioning or operant conditioning, or modelling or cognition (Bloch 1982). Both neurosis and psychosis are, in essence, examples of maladaptive behaviour and learned habits that have been maintained. Therefore, the overt symptoms (the learned behaviour), not the secondary manifestation of disease or unconscious conflict, are to be treated since they themselves are the problem. The goal of treatment is to unlearn specific patterns of behaviour and to replace them with more adaptive patterns. Pavlov, Watson and Guthrie, as pioneers of the behavioural therapy concept, developed the theory of conditioned learning. Burgess (1981) described the typical course of behavioural therapy as:

1. Determining the behaviour to be modified
2. Establishing the conditions under which the behaviour occurs
3. Determining the factors responsible for the persistence of behaviour
4. Selecting a set of treatment conditions
5. Arranging a schedule of training.

The conditions that precede the behaviour may be modified by such techniques as desensitization, reciprocal inhibition and conditioned avoidance. The conditions resulting from the behaviour may be modified by positive reinforcement or negative reinforcement, aversive

conditioning and extinction. Behaviour therapy offers several possible advantages to other forms of treatment, including shorter duration of treatment and applicability to a broad range of patients.

A new approach which has stemmed from behavioural therapy is cognitive behaviour modification. Cognitive therapy or cognitive restructuring is considered by Smail (1978) as an attempt made by Behaviourism to cope with a major problem which had been faced with no adequate resolution. This problem was,

"How to accommodate changes which are forced upon the therapist by practical experience within a scientific dogma which is woefully inadequate for dealing with them."

Kihlstrom and Nasby (1981) agreed that the emergence of the cognitive viewpoint within experimental psychology has created a sort of crisis within the behavioural movement, as several of its influential practitioners began to question their allegiance to the principles and procedures of learning theory. Bloch (1982) explained that, unlike theories of learning, cognitive theory postulates that a person's thoughts or cognition are primarily determined behaviour. In neurosis and especially in depression where low self-esteem is such a common feature, the notion is advanced that the patient's thoughts about himself are that he has little to offer or has achieved nothing or deserves criticism. Aaron Beck (1976), for instance, believes that a depressed person has misinterpreted aspects of reality through processes of distortion and exaggeration and that the resultant thoughts have become automatic, something of an entrenched habit. Therefore the main priority in Beck's approach to therapy is to "correct faulty conceptions and self signals" aiming at abolishing the negative automatic thoughts and promoting realistic thinking. The significance of

cognitive therapy lies in the attempt to deal with emotions through thoughts.

Meichenbaum (1977) developed his programme of "self-instructional training" which is based on the assumption that

"the things people say to themselves determine the rest of the things they do."

He differed from Beck in relating human behaviour to a number of various constructs: physiological responses, affective reactions, cognitions, and interpersonal interactions; and that the internal dialogue is only one of these activities or constructs. He used the internal dialogue as a procedure or a medium for self instruction and behaviour control. Although the Meichenbaum approach has a promising beginning, he recognises its incompleteness both in theory and practice.

3.4.6 Biological Model

This model, as discussed by Burgess (1981), is the one that has helped to control the uncontrollable behaviour of mentally ill patients, particularly psychotics, and thus opened the field to other psychotherapeutic approaches to actively contribute to uncovering the myth of mental illness. She considers that the modern origins of the biological model can be traced to Emil D Kraepelin, an eminent German psychiatrist whose approach is known as the "nosological concept". He was able to provide a classification of mental illness which, with some modification, is still in use. The biological model views psychiatric illness as a disease like any other, with a supposition that eventually there will be found an etiology related to the functional anatomy of the brain. This model relies heavily on etiology, pathogenesis, signs and symptoms, differential diagnoses,

somatic treatment and prognosis. As a result the following conceptual foundations were provided:

1. Development and use of antipsychotic and antidepressant medication
2. The development of mathematical techniques such as factor analysis which facilitate the validation of clinical syndromes and predict the response to drugs
3. Studies of the genetic transmission of mental illness
4. Metabolic studies of psychiatric illness, especially depression.

Clinicians who rigidly hold one particular model to explain or understand the psychiatric phenomena would obviously find little use in alternative models. Although many of the psychiatric care units, especially in teaching hospitals, would claim that they utilise individual therapy as well as social techniques of therapeutic community, yet, in the practice of teaching, research and economics, the decisions made automatically cause the biological model to predominate (Burgess, 1981).

3.4.7 Social Model

This model was introduced to psychotherapy as early as the latter part of the eighteenth century under the name of "moral therapy" by William Tuke (1732-1822), an English Quaker layman; and later by his grandson, Daniel Tuke (1827-1895), a leading figure in British psychiatry (Burgess, 1981). However, the greatest impetus to the social model was received from Adolph Meyer and Harry Sullivan in the first half of this century. Since then the psychiatric ward has been viewed as a social system, the relationship between social class and mental illness has been established and epidemiological studies have been carried out (Mishler, 1981). As a consequence group and family therapy began to take place, day hospitals,

walk-in clinics and day centres provided new ways of treatment without separating the mentally ill patient from his/her social environment. The social model philosophy aims to help the patient to a better understanding of the social system and how he/she relates to it. The social therapist believes that the personality is neither diseased nor in need of fundamental restructuring. What could be needed might be the restructuring of the 'nuclear' social system, ie the family, or even an attempt to impact the broader social system such as housing or education issues.

The social model focuses on the way the individual functions in the social system. Symptoms are traced, not to conflicts within the mind, nor to manifestations of psychiatric disease, but to the "relationship of the individual to his manner of functioning in social situations." The social model adopts the basic concept of helping the patient through maintaining a therapeutic milieu; therefore it fosters approaches like occupational therapy and art therapy.

So far the discussion has focused on the therapeutic approaches used in individual psychotherapy. It is relevant in this context to mention briefly some forms of group therapy that were included in the FIA strategies. The use of group therapy with individual therapy was practised by Schilder in 1939 (Brown and Pedder, 1979). Group therapy in this context is complementary to the individual psychotherapy approach. The value of patients sharing their experience in a therapeutic context was recognised by both the patient and the researcher.

3.4.8 Group Therapy

The human species are social animals, living within groups at work, play and home. It is no wonder then that many of the emotional problems

encountered in psychiatric practice stem from disturbed relationships within these groups. Groups are naturally formed, like families, colleagues at work, or artificially formed, like planned groups for therapeutic purposes. Bloch (1982) related the development of group therapy to the social model of care, while Brown and Pedder (1979) related it to the development of object-relations theory in psychoanalysis. They found that theorists like Fairbairn, Guntrip and Winnicott have suggested that the primary motivational drive in man is to seek a relationship with others at different stages of life. They explain the example of the infant, which although not seeking gratification of an oral impulse does find satisfaction through the feeding relationship.

From an historical point of view, Walton (1978) claimed that Pratt (1907) was the first person to formulate social meetings on a weekly basis to provide instruction and mutual support for his patients suffering from tuberculosis but who refused sanatorium treatment. Subsequently other groups started to appear for the treatment of specific problems like alcoholism. Some of them were directed by laymen.

On the other hand, Whiteley and Gordon (1979) regarded Le Bon's (1895) study of crowd phenomena as the root for studying group behaviour. They also found that McDougall's thesis of 1920 had asserted the reality of a group mind independent of the individual group members (McDougall, 1920). Freud had obviously anticipated group therapy in his book "Group Psychology and the Analysis of the Ego" (1921). He noted that the "group mind" is capable of more productive work such as the development of language and folklore. Yet Jung (1960) rejected this approach as he regarded psychological illness as an individual experience which required individual analysis. Walton (1978) defined group therapy as a

"form of treatment (which) calls for the same small group of patients to meet together regularly with a trained conductor, the aim being to achieve symptom relief and personality change."

This definition is mainly applicable to the classical form of group therapy which was called 'small group therapy' or T groups (T = training). Other forms of therapy have emerged like the therapeutic communities of Maxwell Jones (1956) and the milieu therapy. The term therapeutic community refers to the use of the social environment to help in the treatment of the patient's malfunction areas. Jones (1968) suggested that helping patients should no longer be as isolated individual cases but intimately bound up with family groups and society at large. Therefore the use of therapeutic potential should take place whichever this community may be, eg hospital, prison, etc. Maxwell Jones's model emphasised four themes: democratisation; person awareness; communalism; and reality confrontation. This model of group involvement appeared to be successful, the reasons claimed being due to autonomy and independence gained from peer group support, with staff control seemingly restrained.

Another important form of group therapy is the encounter group developed by Carl Rogers (1969) which ranges from creative "workshops" through sensitivity groups and T groups. Encounter group therapy aims at increasing the person's psychological perceptiveness. To Carl Rogers (1970), an encounter is basically a meeting between one person and another, where each begins to experience the other as a real person in a closer and more direct contact than that usually found in ordinary life, and without the customary inhibitions and social conventions that prevent the expression of genuine feelings, both positive and negative. Rogers, with his background of individual psychotherapy and counselling, was able to use a psychoanalytic approach in an intensive group experience as a means of

developing interpersonal communication and relationships. Yalom (1931) and Walton (1978), however, have warned against the employment of psycho-analytic methods in groups. On the other hand, Brown and Pedder (1974) regarded it thus,

"Analytic psychotherapy in groups, like that conducted on an individual basis, aims to help the individual to resolve conflicts and gain greater understanding of himself and others in the interest of fuller growth and development; the aim is insight, plus adjustment to relationships with others."

They also referred to the advantage of 'multiple transferences' which can develop between fellow patients, and the use of feedback.

With regard to naturally formed groups, family therapy and marital therapy are the most important examples of these methods. Studies in this field were begun in the USA by Mittelman (1948), who studied psychoanalytically relationships of married couples, and by Fromm-Reichmann (1948), whose studies were on families with schizophrenic children.

Family and marital therapy focus on the family or marriage as the disturbed unit. Therefore, the family therapist makes a diagnosis at the level of the whole family system and interviews as many of the family as possible and also invites their cooperation. The theory and practice of family and marital therapy encompass counselling, behavioural and action methods as well as those based on analytic psychotherapy and group therapy. Bloch (1982) also recognised another feature, which is that although the growing number of schools of family therapy has resulted in the development of various theories and techniques that differ greatly, yet they all share one basic feature: the goal of any form of family therapy is to change the dynamics of the whole family or family system.

Haley (1971) and Whiteley and Gordon (1979) stated that the idea of trying to change a family appeared in the 1950's, and by the end of this decade it was becoming clearer that family therapy was in fact a new concept rather than merely an additional method of treatment to be added to individual or group therapy. The focus of family treatment was no longer on changing an individual's perceptions, his affect, or his behaviour, but on changing the structure of the family and sequences of behaviour among a group of intimates. Observing families and trying to change them produced very significant new information; yet it appeared that the development of family therapy was not due to a theory but that people were struggling to find a theory to fit their practice.

The most consistently popular model was a "systems theory" derived from cybernetics. This model could deal with interacting elements which responded to each other in a self-corrective manner, which is the way that families seemed to behave (Haley, 1978). Nevertheless, until the end of the decade the various investigators and therapists in that field did not accept any one particular theoretical model. Furthermore, in the 1980's the term 'family' was considered by family therapists to include not only the nuclear family but also the extended family; the term was applied to all systems with a history and a future and included blood relatives, business colleagues and political systems (Bloch, 1982). This development occurred because some family therapists realised that they were considering the family in isolation much as they had once considered the individual in isolation.

Haley (1978) proposed a therapeutic model for family therapy known as "Problem-Solving therapy". The technique is based on problem-solving approaches which tend to identify the problem rather than the cause. A

very important component of the technique is to include all the family members in the therapy sessions as far as possible. It is most important that for the first interview all family members must be present. Observing family behaviour is not only concerned with the interactive process and relationships but it is also of importance to note how they choose to be seated in the interview room. The therapist must be clear about the objective of the session and encourage the family members to actively participate in the solution. Sometimes a directive approach may be required. The therapist must be aware of the hierarchy in the family and make use of the most influential person in the family to bring them all together.

Relevant aspects of Haley's problem-solving approach were included in the FIA. This approach, however, was not all relevant to the techniques of the FIA, firstly, because the initial interview was always with hospitalised patients; and secondly, it was difficult to involve children in the discussion of their parents' marital problems. Haley's approach also relied on the family to provide and pay for help; this was not found to be the case in either Sheffield or Cairo. Examples of family therapy sessions used in the current study are included in the case studies.

3.5 Practical Implementation and Limitations of the FIA - Psychotherapeutic

The above brief descriptions of the different modalities of psychotherapy serve to help review the practical implications of the FIA. In other words, a combination of several principles from different approaches could be used with one individual patient to manage a single identified problem; eg, Yassin's case study (Chapter 5), presented a model which used support and encouragement to help the patient to talk about his problem (supportive psychotherapy); gain awareness and knowledge of his real

feelings and develop the ability to verbalise them (insight-oriented therapy); such processes would not have been possible unless the patient-therapist interaction process was genuinely based on trust and readiness to cooperate (sociotherapy); followed by the patient's acceptance of responsibility towards himself and his treatment (existential); followed by facing up to the problem of coping with his reactions and controlling his anger by being exposed to provocative stimulation; ie the letters and photos of his ex-beloved (desensitisation). Finally, planning for the future, ie to find a job, and building up a successful relationship with his wife (reality therapy). In addition, marital therapy was included to deal with the most threatening problem he had to face, which was going back into his own community, living with the stigma of mental illness and his family's acceptance/rejection of his past behaviour with women.

During the actual practice such significant distinctions among principles at different stages of therapy were not clear. A combination of several principles took place during the same session. Some scientists and psychotherapists would agree with or support this trend; others may express doubt and criticism about the effectiveness of this approach and its scientific system.

The first problem with the FIA is that it is highly personal, uses common sense to make appropriate decisions and form a reasonable plan. However this problem was handled by using the multi-disciplinary decision which also included the patient's acceptance/refusal/request (democratic system). The researcher was able to employ the "ideological neutrality" of her function as a nurse to promote and balance the implementation process according to the work situation. Another problem could be concerned with the assurance needed that using a scientific therapeutic technique is

helping the patient without any risk of damage; this was reduced to a minimum by continuous monitoring of the patient's response to the strategies used.

It is quite clear that the FIA uses a set number of techniques that are followed in a specific hierarchy or are applicable to most types of problems, as would appear from the nursing point of view as detailed in the following section. The FIA is selective, flexible, changeable and as comprehensive as possible. However, this problem has again found resolution in different literature; eg Freud (1916) considered psychoanalytic psychotherapy akin to a game of chess as he wrote:

"Anyone who hopes to learn the noble game of chess from books will soon discover that only the openings and end-games admit of an exhaustive, systematic presentation and that the infinite variety of moves which develop after the opening defy any such description."

Therefore the use of common sense in such situations is quite relevant. Common sense here does not mean haphazard unstructured processes of trial and error. On the contrary, Haveliwala et al (1979) described it as

- "1. Using common sense in the helping situation means using the common knowledge open to anyone who has become an adult member of a society. This knowledge is knowledge that has been tested and found practical. Applying common experience in therapy means remembering to be practical and not letting a cherished professional doctrine or method become a dogmatic explanation for behaviour.
2. Let your common sense guide your choice of words.
3. Avoiding locking yourself into a static treatment plan.

Classifications are always unsatisfactory when put into day-to-day use. Situations are relative, responding not only to the demands of the personal problems of the moment but also to rules, laws and policies, as well as to available resources."

Using Haveliwala's guiding code of "common sense" in therapy would

emphasise that therapists who stick blindly to a dominant school of therapy are not in fact working with the patient, but at the patient; ie not helping the patient but experimenting with a human being.

Working with the patient and not at him lies in many ways within the phenomenological frame of reference. Rychlök (1982) regarded logical phenomenology as a potent force in the development of psychological theory, rather than it being a variant form of method. He explained that

"Psychotherapy of all types can be seen to 'work' only because there is in fact some kind of re-conceptualisation, or re-evaluation of grounding premises by the client, therapist, or both. Many of these ideological facets of behaviour are overlooked because they occur, or are 'in operation', informally. The specific therapy technique, or ideology of a 'school' of psychotherapy misses such very basic, fundamentally human capacities because they are so natural and generally accepted as the 'given' or the 'obvious' manifestations of what takes place."

A third problem that could be raised is the issue of finding a common base for integration of these theories despite the well-recognised conflicts that exist between them.

A similar trend was found in the approach by Kuhlman (1982) to integrate the use of psychodynamic and behavioural methods in psychotherapy. By means of a case study he presented his therapeutic technique which was based on a "symptom-centering strategy", which used guided imagery techniques of systematic desensitization as instrumental in a client's acquisition of insight and symptom relief. The therapy began usually with the desensitization method but moved eventually to the insight-oriented therapy. Preference for one school was not conclusive. This proves the importance of flexibility and changeability during the course of therapy.

Contradictions in obtained results based on measuring patients' outcomes

are not only attributable to the different schools of therapy but they are even to be found within the same school of therapy. Piper et al (1984) compared four forms of psychotherapy: long-term group therapy, short-term individual therapy, long-term individual therapy, short-term group therapy. Therapy outcome, therapy process and cost-effectiveness were examined. Their results indicated the importance of the components of a particular form of therapy received, over the type of therapy or its duration. Here again is further evidence for the importance of developing techniques suitable for the patient's needs rather than adopting a fixed frozen method that might not be of any help.

The incorporation of eclecticism in the current study was not only applied to the individual psychotherapy model but also involved in group therapy techniques. Patients were not viewed as separate organisms from their society but completely the opposite; patients were very much helped as members of a group. The group could be other patients on the ward during his/her hospitalisation; or the hospital staff; or the family or colleagues at work; or members of a society of significance to the patient.

Consequently, different types of group therapy were used with different patients according to the appropriateness of the therapy and its availability. For example, in Geoffrey's case study (Chapter 5), he was able to join a number of therapy groups, such as the communication group to help him to accept and recognise the importance of opening up about his problems in the presence of the other patients; ie to develop trust in the therapist and others. He also joined an Alcoholics Anonymous group to acknowledge his alcoholic problem and that he was not the only one who was suffering with it, and to help him start to become active and positive about resolving the problem instead of denying it. Family therapy

was also quite valuable in Geoffrey's case, as the wife was also in need of support and a better understanding of her husband's intra-psychic conflict. As a result, better understanding between the couple developed and the wife was more able to support her husband during his course of therapy in the community.

3.6 Practical Implementation of FIA - Nursing Process

The researcher being of a nursing background, the nursing process was therefore of quite major relevance also. The position with the nursing process is again eclectic. Each nursing process employs different techniques to identify patient needs and develop a strategy to meet such needs; so the problem-solving technique was the one most appropriate to this study. Francis's (1967) model of the nursing process as a "problem-solving" approach was included as a framework for intervention; however, the technique was not identical to her approach.

Identification of the problem(s) on many occasions took the form of a continuous process; ie more and more problems were identified, became clearer or were moved to advanced priority during the course of the therapy. Also, some of the problems were resolved just by talking and acknowledging their presence. Some others were beyond the capacity of a therapeutic situation to resolve them. In this sense, the implemented nursing process was eclectic and changeable.

In brief, Francis adopted the scientific method of problem-solving as a model for the nursing process. She rejected other types of problem-solving techniques, either because of their low level, as in the case of unlearned, inherent problem-solving; or because of their unscientific base, as in the case of trial-and-error problem-solving and insight problem-solving. She

also rejected the 'Vicarious' problem-solving method. Vicarious is used in the sense of "experienced or realised through imaginative participation". Here the problem-solver extends his/her sensory range to predict consequences that may or may not occur, but which could greatly reduce the possibility of error. The limitations of this method, however, are that it is based on assumptions rather than facts. Therefore, from her point of view, the most efficient method of solving problems is the scientific one. It has been defined as

"an orderly manner of thinking or of handling data, a systematic pursuit of knowledge and discovering the logical whole from the component parts . . . or going from the part to the whole."

She identified six steps that constitute the formal scientific method of problem solving. They are: (1) understanding the problem, which includes delimiting, defining and describing it; (2) collecting data; (3) formulating an hypothesis; (4) evaluating the hypothesis; (5) testing the hypothesis; and (6) forming conclusions.

She claimed that a simplified and pragmatic version of the process has been adopted by both medicine and nursing; doctors call it "examination-diagnosis-treatment" and nurses call it "facts-assumptions-action". She also claimed that the steps are used under different names; eg the first step is known as "observation"; the middle step as "nursing diagnosis"; and the last step as "nursing care" or "intervention".

On the other hand, Altschul (1978) developed another method for nursing process called "systems approach". She argued that for psychiatric patients the nursing process based on a systems approach may be more useful than that based on problem-solving or activities of daily living. She explained that the existing model of nursing process is very much

concerned to document what nurses do in psychiatric nursing; the postulate is that patients benefit not from what is done but from the way it is done, as the "chief instrument the nurse uses is her own personality".

In psychiatric nursing, patients' activities of daily living are of importance but even more important are

" . . . such activities as the exercise of responsibility, authority and decision-making may be disordered and there is no simple nursing plan which can remedy these disorders."

According to Altschul, nurses have in recent years been influenced by systems thinking and systems management. Nevertheless, the growing body of knowledge of systems behaviour, systems modelling and systems analysis will sooner or later influence overtly the thinking of the nurse and, specifically, the psychiatric nurse. The structure of the systems approach is based upon:

1. Component parts of a system

All systems are inter-related but at any one time only part of a system can be considered and is described as a subsystem. Therefore the nurse cares for a particular subsystem at any given time. The claim that she should care for the whole patient is impossible and probably undesirable. The nurse would create a system that would include the patient's presented disorders but, on the other hand, would consider a specific subsystem for immediate intervention. Thus care can be based on a realistic assessment of the relevant components of the systems.

2. Inside or outside of the system

Inside the system is listed the component parts of the system. The outside is the environment and how it may or may not penetrate the boundary of the system.

3. Changing the boundaries or the interface of the system

The boundary between systems can be re-drawn to incorporate some environmental components to form new subsystems as required.

4. The impact of the environment

To evaluate the extent to which the environment affects the system and whether it is supportive or destructive.

5. Input, throughput and output

These are considered to be very important concepts as they are used in all operational research. The throughput is not a mechanistic process linking input and output but is the activity of the system itself.

6. Distinction between open and closed systems

A closed system is one in which boundaries between the system and the environment have clear demarcations; an open system is one in which constant exchange occurs between the environment and the system. A static system is one which can be described as a steady state; a dynamic system is one which constantly makes inroads on the environment. In actual fact, however, a static closed system cannot be maintained without constant input or it would degenerate.

From the researcher's point of view, both the scientific model of Francis' problem-solving nursing process, and Altschul's systems approach are

similar in some aspects and complementary in others. Both have emphasised the importance of identifying the problem on the basis of assessment. Gathering all the necessary and relevant information about the system (data collection); both stress the importance of analysis of the data they have and its impact on patient care. Altschul's systems approach was complementary to Francis's model, in its study of the impact of the environment (the outside) on the inside; also it studied the input, throughput and output relationship. On the other hand, Francis's model emphasised the importance of evaluating and testing the hypothesis made by the nurse regarding patient care, as the nature of mental illness requires constant exploration of the validity of assumptions made and data collected.

From a practical point of view, the example of Sherifa's case study (Chapter 5) is useful to present the implemented model of nursing process that incorporated both the scientific problem solving technique of Francis and Altschul's systems approach. For Sherifa all the components of the system were studied and listed, ie her emotional problem, family dimension and troubles, social pressures, financial difficulties and educational problems. All these were from the horizontal aspect, whilst the vertical aspect examined the historical development of all these problem areas and their impact on the patient's future and that of the therapeutic plan. Accordingly a hierarchy of priorities was developed and selected, identified problems were investigated for immediate action. Sherifa agreed that the most urgent problem was to notify her family of her marital problem (identification of the problem, inside/outside of the system); data about this problem and the family background were obtained (data collection and input); assumptions about the family's possible reactions were formulated (formulating hypothesis and impact of the

environment); approaching the family in reality (evaluating hypothesis); informing the family of the problem (testing hypothesis and throughput); directing the family's reaction towards positive support for the patient and her therapy (conclusion and output); moving to another problem (distinction between open and closed systems).

3.7 Conclusions

The previous discussion of various models and schools, whether of nursing or psychotherapy, has identified some of the problems associated with therapeutic intervention and decision-making. Therapists who adhere to one model may be accused of following an incomplete theory, and of directing patients to conform to such a theory, instead of adjusting the theory to the needs of patients (Haveliwala et al 1979). By contrast, therapists who adopt a flexible approach may be accused of selectivity, subjectivity and of failing to follow an empirical approach (Beutler, 1983).

Despite great divergence among theories of mental illness and psychotherapy, there is important common ground which could help to combine them with less conflict. This is the capacity of human beings to be studied from more than one point of view. In the main, theorists in the field of psychotherapy have tried to apply principles learned within the nomothetic sciences to spiritual, psychological or psychosocial aspects of the self; a strategy copied by their nursing counterparts. There is, however, an emergent movement to find other ways of describing human behaviour which could view each individual patient's behaviour holistically.

The FIA uses the phenomenological approach as a starting-point for such a method: and borrows from the existential school the principles of being

responsible, and of taking control of one's own world, within the limits imposed by biological, psychological and social factors of growth and development. Within it, behavioural change is viewed not simply as a continuous, spontaneous process, governed by such factors; but also as a deliberate, conscious effort made by a person to produce planned outcomes suited to his/her understanding of the world.

This approach is critical of the assumption that a "normal" human being must be competent in materialistic terms; should love because that is "good", whereas to hate is "terrible"; should be sexually adjusted and enjoy sex; should be happy and free from anxiety, depression or fear. Though implicit in many therapeutic approaches, these assumptions are not very realistic in the everyday world. The FIA regards life as a complex mixture of experiences, and a myriad of potential responses, which are unique to the individual. It is to be hoped that, the greater the number of therapeutic approaches, the more likely it is that ideas will be generated which will lead to increasingly collaborative attempts to help the individual's adjustment to his/her complex world.

CHAPTER 4: METHODOLOGY

4.1 Introduction

4.2 Research Design

4.2.1 Part One: Theoretical Background of the Study

4.2.1.1 Qualitative/Quantitative Techniques

4.2.1.2 The Nature of the Study

Quasi-Experimental; Action Research

4.2.1.3 Data Collection Strategies

Observation; In-depth Interview

Self-Report Questionnaires

4.2.1.4 Sampling

4.2.1.5 Limitations of the Proposed Research Design

4.2.2 Part Two: The Technical Design of the Study

4.2.2.1 Cross-cultural Aspects

4.2.2.2 The Two Phases of the Study

4.3 Methods of Data Collection

4.3.1 Semi-Participant Observation

4.3.2 In-depth Interviews

4.3.3 Self-Report Questionnaires

4.3.4 Checklists: The Behavioural Adjustment Inventory (BAI) and its Recovery Index RI

4.3.5 Data Collection Instruments

- In Sheffield; In Cairo

4.3.6 Development of the Behavioural Adjustment Inventory (BAI)

4.3.6.1 Main Purposes of the BAI

4.3.6.2 Theoretical Background of the BAI

- 4.3.6.3 Structural Components of the BAI
- 4.3.6.4 Technical Development of the BAI
- 4.3.6.5 Development of the Recovery Index (RI)
- 4.3.6.6 Theoretical Bases of RI Development
- 4.3.6.7 Limitations of the BAI₁₀₀ and its RI
- 4.3.6.8 Validation Phase and New Version of the BAI
- 4.3.6.9 Testing Validity and Inter-Rater Reliability of
the BAI₃₀ in Cairo
- 4.4 Sampling Strategy
 - 4.4.1 In Sheffield
 - 4.4.2 In Cairo
- 4.5 Implementation of Bridging Therapy
 - 4.5.1 In Sheffield
 - 4.5.1.1 Bridging Therapy compared with the current conventional
provision
 - 4.5.2 In Cairo
- 4.6 Methodological Limitations of the Current Study
- 4.7 Summary

CHAPTER 4: METHODOLOGY

4.1 Introduction

The previous chapters have demonstrated the theoretical basis for developing an innovative approach to community psychiatric nursing care called bridging therapy; and the logic behind its implementation in two different settings, and two different cultures. This chapter offers a theoretical framework and justification for the methods used; and reviews the expected problems arising in the work plan in the first section (Part (1)). The second section (Part (2)) deals with the process of implementation; the strategies for dealing with anticipated problems; and offers a critical analysis of the study design.

The plan of work in this chapter is to demonstrate an innovative research design which incorporates both qualitative and quantitative features in evaluation research. The result of this attempt is called a "methodological mix" design. It is based on recommended well-known research styles, including quasi-experimentation and action research.

The objective of the researcher in this chapter is to demonstrate the actual process of building such an innovative methodological design rather than to become immersed in the partisan debates concerning two different philosophies of science (positivism and phenomenology).

4.2 Research Design

4.2.1 Part One: Theoretical Background of the Study:

The present study has a complex structure derived from a number of different theoretical approaches. This is due to the complex nature of

any inquiry which studies human beings and their behaviour. As will appear from the review in this section, the use of a mixed form of methodology often becomes a necessity in the field of human sciences, where factors under study become extremely difficult to isolate (Lincoln and Guba, 1986). The present study was to take place in a social setting (hospital and community); in two different countries (Britain and Egypt); with and for human beings (patients and staff), to assess the outcomes of a new approach to treatment (bridging therapy) which it is hypothesised may improve existing psychiatric nursing services in both contexts.

The complex nature of this study justified the employment of both quantitative and qualitative methods of research. The use of combined methods has been encouraged by many authors who regard this trend to be sensible and practical since both quantitative and qualitative methods are complementary rather than contradictory (Reichardt & Cook, 1979; Silverman, 1985; and Kirk and Miller 1986).

Patton (1980) gives this approach the title "methodological mixes". He identifies six categories of mixed methodological strategies for measurement, design and analytic components of hypothetico-deductive and holistic-inductive paradigms. According to Patton the present study uses one of these methodological mixes called the "mixed form: naturalistic inquiry with qualitative measurement and statistical analysis".

4.2.1.1 Qualitative/Quantitative Techniques:

The logic underlying the use of combined methods in the current study is evidenced in the critiques of each method independently used. By definition qualitative methods are

"....detailed descriptions of situations, events, peoples' interactions and observed behaviour; direct quotations from people about their experience, beliefs and thoughts." (Patton, 1980)

while quantitative methods are defined by Lincoln and Guba (1986) as
"....exploring the truth value of the inquiry or evaluation (internal validity); its applicability, external validity or generalisability; its consistency (reliability or replicability), and its neutrality (objectivity)".

Increased dissatisfaction with sole reliance on conventional positivistic paradigms has been growing fast in the last decade (Ianni and Orr, 1979). Conversely, qualitative methods cannot match existing positivistic theories of rigorous research design (Silverman, 1985).

A number of fundamental problems limit the use of a single method, either qualitative or quantitative, alone. These problems may be summarised under three main categories: (1) "Rigorous" vs "Relaxed" method; (2) Hypothetico-deductive vs Holistic-inductive method, and (3) Objectivity vs Subjectivity.

With regard to the first category, the current research accepts the positivists' use of rigid modes of study to ensure validity and reliability of the information obtained and to make 'causal' inferences. As a result, however, research may become divorced from the real world, leading to recurrent disappointment manifested in "lack of significance" in experimental naturalistic studies (Lincoln and Guba, 1986).

Qualitative researchers therefore attempt to find rigorous conceptual frameworks to avoid the accusation of "relaxed" method, which has negative

overtones. For example Patton (1980) uses the term 'flexible' rather than 'relaxed', Maanen (1982) describes it in terms of certain, axiomatic-like beliefs or principles held by a researcher, and Ianni and Orr (1979) as a combination of simple design, rational inquiry and complex technique. Other authors who desire a rapprochement of rigorous and naturalistic methods have suggested new models, e.g. triangulation (Denzin, 1978); quasi-experimentation (Cook and Campbell, 1979); interpretivist (Silverman, 1985); and trustworthiness and authenticity (Lincoln and Guba, 1986). Discussion of the quasi-experimental model is included later in this section.

The second category (hypothetico-deductive vs holistic-inductive) implies that formulating hypotheses based on assumptions implicit in a theory may run the risk of misinterpretation of ambiguous meanings (Selltiz et al 1976). Similarly, holistic inquiry may run the risk of misinterpreting phenomena because of the variation of perception among individuals (Lincoln and Guba, 1986). However, holistic researchers argue in favour of multiple constructed realities, which cannot be studied as discrete variables.

The third category concerns objectivity vs subjectivity. Positivists claim to assert independent standards to satisfy factual requirements that recognise no authority of persons in the realm of cognition (Scheffler, 1967). However, Kirk and Miller (1986) describe such complete objectivity as a fallacious assumption. Furthermore, Maanen (1982) disqualifies the objectivity and strength of quantitative studies on the basis of the researcher's inherent subjectivity; e.g. an individual frame of reference based on the researcher's theoretical background; the selected point of study; selectivity in tabulating results; and interpretation/analysis of results. Such subjectivity of the researcher may lead to dangerous bias

and misleading results if the researcher's judgement is clouded by factors like ethnicity, rigid attitudes and lack of training in appropriate techniques.

Maanen (1982) identified five controlling principles for researcher subjectivity in naturalistic research. These include analytic induction; proximity; ordinary behaviour; structure as natural constraint; and descriptive focus. In addition Lincoln and Guba (1986) suggest the need for recognition of the interactive nature of the relationship between the researcher and respondent. This is a relationship of mutual and simultaneous influence, which, when successfully established, becomes one of respectful negotiation, joint control and reciprocal learning. This view conforms with Kirk and Miller (1986) recommendation to regard validity as of primary, and reliability as of purely secondary importance. They make the assumption that reliability could be misleading and inapplicable in a changing world.

The above arguments stress the complementary nature of quantitative and qualitative research styles; and emphasise the desirability of a combined approach. Reichardt and Cook (1979) point out that the debate concerning the use of qualitative or quantitative methods in evaluation research is often inappropriately stated:

"....There is no need for a dichotomy between the method-types and there is every reason (at least in logic) to use them together to satisfy the demands of evaluation research in the most efficacious manner possible. Hopefully, the next generation of evaluators will be trained in both qualitative and quantitative traditions. These researchers will be able to use the broadest possible range of methods and will tailor the techniques to research problems without parochialism...."

The adoption of a similar attitude with particular reference to psychiatric research is encouraged by Carstairs (1968). He writes of "pure" experimentalists as follows:

"....to meet the requirement of a tidy research design, they would like to be able to examine the effects of one variable at a time, or if several variables are necessarily involved, they would like to be able to assign numerical values to each variable. In practice, however, they find that any mental health programme involves a multiplicity of interacting variables and its outcome may also be manifested in several different ways."

Foster (1987) draws attention to the inadequacies of "elegant" research design in meeting the requirements of practical application, especially in cross-cultural settings. He finds evidence to suggest that followers of such design cost the World Health Organisation wastage of its "behavioural research dollar". He regards physician-dominated research committees as responsible, since they tend to assume that quantitative, hypothesis-testing investigation is the only acceptable research model. Foster calls for the inclusion of qualitative approaches in order to encourage a higher quality of inquiry, revealing socio-cultural as well as medical factors in the assessment of effective delivery of health care programmes in cross-cultural settings.

The recommendation to use the 'methodological mix' approach in nursing research was specifically stressed by Goodwin and Goodwin (1984). They pointed out that many research studies have multiple purposes that require a comprehensiveness which neither approach, if used alone, could achieve.

The above discussion demonstrates the theoretical logic of this proposed research design, which adopts relevant techniques from both quantitative and qualitative approaches.

4.2.1.2 The Nature of the Study:

It was mentioned earlier that the complexity of the current research dictated the multidimensional method of investigation. It uses Patton's (1980) "mixed" method, which he identifies as: "mixed form: naturalistic

inquiry: qualitative measurement and statistical analysis." This mixed form in the current study employs a combination of some quasi-experimentation principles with action research techniques. The following section examines both models in some detail, with discussion of their possible applicability in the current study.

Quasi-Experimental:

This was an attempt by Campbell and Stanley (1963) to develop a research model that could deal with research difficulties encountered during the implementation of true experimental design in the field of human sciences.

In this sense a quasi-experimental design is one of the attempts to develop rigorous methodology in social and behavioural sciences. The current research design adopts principles of the quasi-experimental design which places special emphasis on experiments that have treatments, outcome, measures, and experimental units, but does not use random assignments to create comparisons from which treatment-induced change is inferred. Instead, the comparisons depend on non-equivalent groups that differ from each other in many other respects than simply the presence of a treatment whose effect is being tested (Cook and Campbell, 1979). Threats to such designs mainly concern the nature of valid causal inference. The researcher acknowledges this threat; and suggestions by Cohen and Manion (1986) to deal with it were considered in the current design. These authors regard the use of "equivalent" controls strengthened by matching as an improvement in such designs. However, they also accept the possible failure of matching to provide the intended equation.

Threats to internal and external validity* were also recognised by Cook & Campbell (1979). They identified seven threats to internal validity and six

to external validity of the quasi-experiment. Threats to internal validity include variations in within-experiment history; maturation effects; statistical regression due to unreliability of measurement; latency or within-group effects; pre/post test effects; observer error; selection bias; and experimental mortality. Threats to external validity include faulty description of variables; lack of representativeness in sample; Hawthorne effect**; inadequate operationalisation of variables; experimental sensitivity; and interaction of various confounding variables. Adequate preparation of a quasi-experimental design can help to minimise the effect of these threats.

The above discussion sets out the reasons for employing a quasi-experimental design in the current research. In more specific terms, the present study corresponds most closely to these recommendations for a quasi-experimental comparative design, which examines the effectiveness of bridging therapy for the improvement of the delivery of psychiatric nursing care in two countries (Britain and Egypt).

Assessment of therapeutic outcomes of bridging therapy requires the experimental design to be as rigorous a method for hypothesis-testing as possible. Both internal and external validity are of considerable

* Internal validity is concerned with the question, do the experimental treatments, in fact, make a difference in the specific experiments under scrutiny? External validity asks the question, given these demonstrable effects, to what population or setting can they be generalised? (Cohen and Manion, 1986)

** i.e. psychological contamination effect when subjects realise their role as guinea pigs.

importance in the current study; and a number of measures have been employed to ensure them. These will be discussed in Part (2) along with problems encountered during the implementation/evaluation phases.

According to the above, the design of pretest-post test equivalent control group quasi-experiments was followed for the current study within the more global structure of action research.

As mentioned earlier, naturalistic inquiry requires depth participation of the researcher to ensure holistic examination of the studied phenomena. Therefore 'action research' appeared to be the most suitable style for this combination (methodological mix) in the current study.

The use of action research in nursing is supported by many writers especially in the field of psychiatry and mental health care (cf e.g. Towell and Harries, 1979 and Greenwood, 1984). In the following section discussion of action research style and the logic of its use in the current study is included.

Action Research:

Use of the term varies with time, place, setting and authors; it may prove difficult to find an exact definition. Nonetheless, the definition given by Cohen and Manion (1986) is used in the present study: "...action research is small-scale intervention in the functioning of the real world and close examination of the effects of such intervention."

The use of action research in the social sciences can be resolved into two stages: diagnostic and hypothesis development stage; and a therapeutic stage, in which the hypotheses are tested by a consciously directed change

experiment (Cohen and Manion, 1986).

According to Cohen and Manion, action research has four main characteristics. It is:

"Situational - it is concerned with diagnosing a problem in a specific context and attempting to solve it in that context....., Collaborative teams of researchers and practitioners work together on a project, it is participatory - team members themselves take part directly or indirectly in implementing the research; and it is self-evaluative - modifications are continuously evaluated within the organisation situation, the ultimate objective being to improve practice in some way or other..."

Having identified these characteristics, action research appeared particularly suitable for the purposes of the current study. This is because bridging therapy seeks to improve certain aspects of psychiatric nursing care in a cross-cultural setting. Accordingly, bridging therapy is introduced to be integrated within the current health system of both countries. Participation of other members of the health team is of prime importance for its implementation and evaluation. The depth participation of the researcher in implementation of the programme; the quest for realistic assessment of the real situations under study; as well as continuous evaluation of the programme in progress, and the need to introduce on-the-spot modifications and/or changes make this approach eminently suitable to the present study.

Critics of action research, however, find some grounds for negative comment, concerning issues such as objectivity, validity, reliability and generalisation of results (Lathlean and Farnish, 1984). Such issues have been discussed exhaustively by many social scientists who claim that action research does not pretend to be objective, but subjectivity is valued rather than criticised (Pedler, 1974) and that experimenter bias and human error exist within the most immune forms of research (Parlett and Hamilton,

1972). Walker (1980) regards action research as in a similar tradition to that of the case study, which relies heavily on face validity, in that the results in both cases seem to fit the reality. The action research approach to external validity was given the name 'naturalistic generalisation' by Elliott and Ebbutt (1983) who defined it as follows:

"An account can be judged to be externally valid if the insights it contains can be generalised beyond the situations studied."

Reliability, in its classic form, is not practically applicable, as discussed earlier in this chapter, citing the views of Kirk and Miller (1986).

By contrast, the intended use of case studies in the current research places the emphasis on 'collecting definitions of situations' (multiple representation); and the presentation of such material in a phenomenological perspective. Generalisation using action research is possible, however, since it is an attempt to mirror the reality of a situation (Lathlean and Farnish, 1984); and will be generalisable to other situations of like kind (Greenwood, 1984).

From the above, it becomes clear that the methodology of the present study is tailored to the purpose of the current inquiry; and that it seeks to meet the complex nature of the investigation. The following section reviews the strategies planned for data collection within the above framework.

4.2.1.3 Data Collection Strategies:

As the current study is field research, working within a "quasi-experimental" frame of reference, and implementing an action research style, it follows that both qualitative and quantitative techniques of data collection are employed.

The present research style should not be confused with the ethnographic style of research or with anthropology per se. Ianni and Orr (1979) make this distinction clear: "...field research techniques hold great potential for use in evaluation; but this should not be confused with anthropology." Data collection methods for the present study included observation (semi-participant), interviewing (indepth interviewing both semi-structured and unstructured) and questionnaires (self report questionnaires). The following is a description of each of the above methods and its utilisation in the present study with the rationale for its choice.

Observation:

Observation is a basic method of data collection. It may be combined with other methods or used separately (Hammersley, 1979). Observation is by definition "a way of collecting data in a purposeful and systematic manner about the behaviour of an individual or group of people at a specific time and place." (Mullings, 1984)

Observation can be viewed on a participant/non-participant continuum which varies from complete immersion as a full participant to complete separation as a spectator (Patton, 1980). Patton also notes the great variations along this continuum, and the extent of researcher-participation which can change over the course of data collection. At one end of the continuum, a researcher may be immersed in the life of the group under study, as in the ethnographic style of research, which was first adopted by anthropologists. Their approach sought 'naturalism', 'holism', 'ecological validity' and 'multiple perspectives' (Hammersley, 1979). The term ethnography is an historical one and originally meant the description of the institutions and customs of peoples (Greek: *ethnos*, *graphein* (Wilson, 1979)). The original use of the word fitted the work of anthropologists of

the early twentieth century, who wanted to study the social and cultural beliefs in the small, simple societies of Africa and the Pacific. This involved collecting data through participation in the lives of these groups (Hammersley, 1979). The concept of ethnographic research encouraged studies based on the method of observation of 'natural' social processes to evolve from being used in exclusively anthropological contexts to wider use by social scientists in modern Western Societies. Examples of this style of research include a study of street gangs in a poor quarter of Boston, USA (Whyte, 1955); a study of bread-round salesmen in England (Ditton, 1977); and a study in the psychiatric field of 'asylums' (Goffman, 1961).

This method of ethnographic research essentially requires learning the language or using an interpreter. Evans-Pritchard (1902-1973), one of the pioneers of anthropological studies, had lived under very difficult circumstances in order to learn the language of the primitive societies in Sudan, Africa. He used participant observation to collect his data, but without being a member of the tribe. His approach was to collect information about certain features of their social lives through observing their rituals, asking questions and holding natural conversations. (Douglas, 1980).

Learning the language of the group under study could be very difficult and very time-consuming. Cox (1976) recommended the use of a good interpreter who can function as mediator specifically in the field of psychiatry. Doctors or nurses working in such native societies, or with immigrant patients from native societies, would find it very difficult to form a clinical judgement without the correct use of a good interpreter. Similarly, an overseas doctor working in the United Kingdom initially finds an interpreter of assistance when getting accustomed to a British

dialect (Cox, 1976). With such a strategy in mind, it becomes clear that the term observation has variable dimensions according to the context of its use. Hammersley on the other hand believes strongly in the central meaning of participation; i.e., adopting an active role and becoming a member of the group. He also believes that participation rather than observation is the means for data collection in ethnographic studies. Ethnographic work, therefore, is not a single homogeneous method, but involves a variety of data collection techniques such as field notes, triangulation, and most importantly participation and participant observation (Hammersley, 1979).

Accordingly Evans-Pritchard's approach to ethnographic studies would appear to be less involved than Hammersley's. Liebow (1967) supports this view when he stresses the inevitability of active involvement at various periods of the observational process:

"Occasionally.....I tried to be an observer only. In practice, I found it impossible to keep all traces of participation out of a straight observer role."

Liebow goes on to stress that the degree of the researcher's participation is as much a matter of his/her self-perception as it is of being accepted as a participant by others.

The general characteristics of participant observations are summed up by Taylor and Bogdan (1984) as

"research that involves social interaction between the researcher and informants in the milieu of the latter, during which data are systematically and unobtrusively collected."

At the other end of the continuum non-participant observation is regarded

as a situation in which the observer does not interact with the subjects at all. Further terms used to describe participant observation include 'unstructured observation', 'field observation', field research and qualitative observation (Mullings, 1984). Mullings views the term semi-participant observation as being the most usual form where some interaction occurs between the observer and the subject, and the relationship maintains its shape on a strictly researcher/subject basis.

Both the nature of the enquiry and the methodological design of the current study entail the participation of the researcher as both nurse/key worker and researcher. This multi-role of the researcher is a very important feature of action research as discussed earlier.

Therefore the importance of using semi-participant observation appears in the following:

- (a) Bridging therapy programmes evolve around therapeutic objectives to help patients towards progress. Sensitivity to patients' needs from a nursing point of view requires this depth involvement at certain stages of the programme.
- (b) Semi-participant observation will supplement the behavioural rating measures with accurate interpretation of the phenomena under study.
- (c) The researcher's background as an Egyptian was different from that of the patients in Sheffield. This different ethnic background necessitated the development of a new orientation to the Western culture of the patients and their moral and sociological systems. This could only be achieved by active participation and in-depth involvement.
- (d) Principles of therapeutic community are employed in ward 56 to a certain degree. Staff-patients hierarchy is maintained. Many of the

patients' adjusting behaviours could be clearly observed and modified within this setting. Consequently semi-participant observation became the most appropriate means of data collection for this particular set of information.

Observation may be either overt, covert; direct or indirect (i.e. reported); structured or unstructured (of e.g. Mullings, 1984). As a quasi-experiment, bridging therapy needed to be evaluated in terms of its efficiency in meeting patients' needs and its effectiveness in influencing their therapeutic progress. Therefore it was decided to use overt, direct and indirect, and semi-participant observational techniques.

The researcher is quite aware of the limitations of observation techniques which may jeopardize its effectiveness. Examples include observer bias; possibility of influencing the subject's behaviour; and its inability to record past or rarely occurring events. To deal with these problems certain measures were undertaken. These included combined instrumentation which employed in-depth interviews, various forms of self-rating questionnaires as well as a specially-developed behavioural inventory to be completed by different members of the therapeutic team.

In-depth Interview:

This type of interview is highly appropriate for the purposes of the present study because of the need to focus on a specific area of study, i.e., psychiatric care and the relative flexibility of the technique.

Taylor and Bogdan (1984) define in-depth qualitative interviewing as:

"....repeated face-to-face encounters between the researcher and informants, directed towards understanding informants' perspectives on their life

experiences or situations as expressed in their own words."

In-depth interviews were utilised in the current study in accordance with the above definition, using both semi-structured and unstructured interviewing techniques. Such techniques are described by Walton & Littmann (1973), as useful in psychiatric interviewing for three purposes: as a diagnostic procedure, as a treatment method; and as a research tool. They viewed structured interviews as useful for research purposes, whilst unstructured or therapeutic interviews generally occur in the context of the developed relationship between the therapist and the patient.

Generally speaking, interviewing aims at: obtaining objective facts from the informants (social survey); obtaining information about the behaviour of the informants, assessing personality and mental state of the informants (psychiatric interview); and to change a person's behaviour (the psychotherapeutic interview).

Interviewing techniques used in the current study aimed at meeting these stated aims as effectively as possible. Thus the researcher aimed to examine the patients' problems as holistically as possible (social, psychiatric, and psychotherapeutic); and to evaluate the effectiveness of bridging therapy in meeting such needs both at an individual level using the flexible integrative approach (FIA) and at the structural level (continuity of care vs conventional system). These issues are considered in more detail in Part Two of this chapter.

Self-report Questionnaire:

This method places heavy reliance upon the validity of verbal reports. Among the many advantages of using a questionnaire technique is its

impersonal nature and the standardised wording, which offer some uniformity for measurement. (Selltiz et al, 1976). The use of questionnaires in psychiatry, however, is fraught with problems especially in the field of cross-cultural psychiatry.

A major problem may be posed by the differing perceptions and interpretation of questions by respondents (Selltiz et al, 1976). Additionally, translation of questions from one language to another can change the meaning of the original question, or make nonsense in a different culture. It may also cause difficulty because it introduces concepts lacking in the other culture (Leff, 1973) (as discussed earlier in Chapter One). As the current study was to take place in two different cultures (Britain and Egypt) the researcher had to ensure the availability of translated standardised questionnaires in Arabic as well as in English. Details of this technique are included in Part Two with regard to the General Health Questionnaire (GHQ) and the Eysenck Personality Inventory (EPI).

Another form of checklist was also planned to rate patients' behavioural adjustment both during hospitalisation and after discharge into the community. This behavioural checklist was to be developed specifically for this study, as the literature search made it clear that an adequate instrument, in terms of combined situational assessment of multiple dimensions (behavioural and social), did not exist. Details of the development of this instrument are outlined in Part Two.

4.2.1.4 Sampling

Purposive Samples:

In the current study the use of strictly random sampling procedures is not

appropriate in view of the following:

Firstly, the quasi-experimental design of the present study accepts Cook and Campbell's (1979) criticisms of randomisation. Their criticisms include ethical issues concerning randomisation of individuals to receive treatment, whilst withholding from others; and the possibility of a high rate of drop-out from the original sample leading to lack of representativeness and misleading generalisation of results.

Secondly, in the field of psychiatric and psychological studies, patients' acceptance of the therapist and the therapeutic programme are necessary. Working within the paradigm of action research, patients' voluntary participation in the research is essential. Action research requires an holistic, naturalistic study of the phenomena in rich qualitative detail; and therefore favours the utilisation of a small sample or case studies rather than a large sample. Here the sample may not necessarily be representative of the entire population, but it should be typical of the target population (Cohen and Manion, 1986).

Thirdly, randomisation presumes that all human response to specific stimuli is identical; and consequently relates the causal inference to effects produced by the introduced variable(s). Such an assumption is not applicable to naturalistic studies using qualitative measures of assessment.

From the above, it becomes apparent that purposive rather than random sampling is most suitable for the present study. The strategy in using purposive sampling is described by Selltitz et al (1976) as follows:

"The basic assumption behind purposive sampling is that with good judgement and an appropriate strategy one can handpick the cases to be

included in the sample and develop samples that are satisfactory in relation to one's needs."

Selltiz et al further emphasise that purposive sampling recognises that the fact of selecting cases judged to be typical of the population in which one is interested assumes that errors of judgement in the selection will tend to counterbalance each other.

With such strategies in mind, the researcher planned to approach every patient on the ward (both in Sheffield and Cairo) whose hospital records revealed them as fulfilling the sampling criteria, after cross-checking with the consultants concerned. All patients who voluntarily agreed to participate in the project were to be assigned to either group (experimental or control) according to their choice and the requirement of the study.

The researcher believes that this technique counteracts to some extent the biases associated with non-randomness, since every subject on the ward or admitted during the course of the sampling procedure had an equal chance to accept or reject participation in the study.

4.2.1.5 Limitations of the Proposed Research Design:

- 1 The proposed research design uses the new trend of combined methods (quantitative and qualitative approaches), a notion which is still in its developmental stage and requires careful implementation.
- 2 This "methodological mix" has the advantage of making use of the qualities offered by each paradigm. On the other hand, it has the disadvantage of inheriting two sets of methodological limitations.
- 3 Principles of quasi-experimentation and action research were adapted and jointly used. Fortunately, there is no inherent conflict between

these two styles as they are rather complementary. However, it is a new attempt and could be confronted with difficulties not accounted for.

- 4 Instruments of data collection include some subjective, unobtrusive techniques such as semi-participant observation and in-depth interviews. These techniques increase the chances of researcher bias both in recording and interpreting the data. In addition, the researcher's halo effect may influence the patients' behaviour, resulting in a distorted set of data.
- 5 Problems of validation may conflict with problems of reliability. In other words, qualitative methods stress the importance of internal validity, whilst quantitative methods stress the importance of generalisability.
- 6 Small-scale purposive sampling: these samples are criticized from a positivistic point of view, since they lack the advantages of representativeness and reduce valid assumptions regarding causal inference.

4.2.2 Part Two: The Technical Design of the Study

This research project as a quasi-experimental comparative study evaluates the effectiveness of bridging therapy (i.e. provision of a model for relatively comprehensive psychiatric nursing care for mentally ill patients to bridge the gap between hospital and community immediately after the patient's discharge). This approach was to be examined in two different contexts, i.e. Sheffield and Cairo, with a comparison of the results.

For purposes of the quasi-experimental study, two groups of patients in both contexts were chosen, one as an experimental group and another as a

matching control on identified criteria (age, sex and nature of disability). Experimental groups received two types of integrated care in the form of the hospital's usual services and the researcher's therapeutic programme, i.e. bridging therapy. The control groups received the hospital's usual service and the usual community service when necessary.

The bridging therapy programme was designed to be integrated with the hospital therapeutic programme and to make use of the hospital facilities as well as those of the community. Details of its structure and implementation are included later in this section.

The intervention was based on the implementation of a number of therapeutic approaches both at group and individual levels. However, the main theme of all these interventions was the problem-solving approach and systems approach as earlier defined in the Nursing Process (Chapter 3). The techniques varied according to the patient's needs, type of disability and abilities or preferences. The proposed comprehensive programme, i.e. bridging therapy, was provided for patients in the experimental group as soon as they were admitted to the hospital and agreed to take part in the project. After discharge, the programme was continued for a period of 3-6 months to cover the gap between hospital and community care and to provide the necessary support for patients in this critical period by the same person whom they had grown to trust. In the case of the control group, they received the usual hospital care based on an individualised care plan, with the use of hospital and community facilities but with no nursing follow-up in the community. A Community Psychiatric Nurse was to take charge of the community care of patients in the control group. Usually this CPN was completely new to the patient, not acquainted with the details of his/her difficulties and traumatic

experiences.

During the implementation of bridging therapy there was some difficulty in dealing with each group as strictly as it should be. On many occasions the researcher had to be involved in the care of some of the patients in the control group both at group level and individual level. On one or two occasions patients who were categorised as controls had to be accepted as experimental because of the depth of involvement which developed.

The comparison of the effectiveness of bridging therapy both in Sheffield and Cairo was conceived as introducing a new concept to community care in a context where community work is getting more and more popular (Sheffield) and in another context where community work is very much under-developed (Cairo) and seeking a new useful system which would help bring about improvement. Although these anticipated differences were thought to provide good grounds for comparison, this proved to be very complicated as it was not possible to compare the psychiatric services without consideration of other influential factors such as the culture, economy, schools of thought and facilities/constraints of the two societies. Therefore the strict comparison of statistically significant differences between rates of progress achieved by experimental groups in Cairo and Sheffield was considered not to be solely sufficient. Instead, it was combined with a descriptive comparison and detailed discussion of case studies.

4.2.2.1 Cross-cultural Aspects of the Study

Cross-cultural comparisons between Westernised societies and developing societies were discussed earlier in Chapter One with particular reference to Britain and Egypt. The nature of this comparative work implies the

wide variety of the audience or readers for this work. In other words this work is directed towards both British and Egyptian audiences. Therefore the following sections will present in some descriptive detail, the context of the experiment both in Sheffield and Cairo. Clearly the Sheffield setting represents Western developed society, while Cairo represents a Middle East developing country.

The Sheffield Setting

Sheffield is a British industrial city with a population of just over half a million inhabitants in a total area of approximately 150 square miles. It is situated in the north Midlands, and is the fourth largest city in England. It is famous for the manufacture of steel, and especially for the manufacture of cutlery and surgical instruments, although these industries have now been run down. The University of Sheffield and Sheffield City Polytechnic are both large academic institutions.

i) The Hospital Community (Ward 56)

Ward 56, Psychiatric Unit, Northern General Hospital, was the optimal choice for this study. It is a psychiatric unit in a teaching hospital with a capacity of 120 beds and a further 100 places in the Day Hospital. The Psychiatric Unit was recently built, being opened only two years before the commencement of this project (1982).

Ward 56 was also considered by its staff and patients to be an advanced ward with an open-doors policy, with total freedom for the patients to move in and out of the hospital as they wish providing they have permission from the nurse in charge.

Ward 56 has 25 beds which are divided unequally between its three

consultants. The ward building consisted of four large rooms with two rooms accommodating five patients each and the other two rooms accommodating six patients each. The privacy of the patients is promoted by heavy curtains around each bed. Usually there is a greater number of female patients on the ward than male patients, therefore the larger rooms are usually occupied by female patients. In addition there are three small single rooms, usually used for selected patients where their therapeutic programme requires them to be separated from the other patients.

The ward has the facilities of utility rooms, hairdressing, communal or TV room, a musical and small library room, and a fully-fitted kitchen.

The ward's main policy is to run a therapeutic community; i.e., the therapeutic team with their different specialities were equal with the patient and both are required to participate in ward activities and setting up the rules for this community. This was achieved by holding a ward meeting twice a week where patients and staff sat down and discussed problems of management and administration and the necessary action(s) to resolve them.

There was an important and active entertainments policy. Parties were regularly held to celebrate patients' birthdays and also for occasions such as Christmas and New Year. Visiting hours are flexible but no visitors can stay after 9.00 pm. Patients were allowed to spend weekends with their families and to take up to two weeks holiday. Patients are able to receive telephone calls on the ward and also have access to a telephone box.

ii) Ward 56 Staff

The ward staff varied considerably, apart from the consultants who were the only consistent members of staff. Generally speaking the staff consisted of:

- a) three psychiatric consultants: 2 professors and 1 senior lecturer.
The 25 beds were divided between them; one professor had 12 beds and the other two consultants shared the rest. Sometimes this policy indirectly influenced the rate of admission and discharge of patients, e.g., in case of an urgent need for a vacant bed.
- b) on average there were 2 lecturers and a variable number of junior psychiatrists and house officers
- c) there were 2 social workers, 1 psychologist, 1 behavioural therapist and 1 dietitian
- d) nursing staff were also very variable but in general there were 2 ward sisters, approximately 10 staff nurses and 2 nurse assistants.

iii) Ward 56's Therapeutic System

Patients were admitted to Ward 56 from the outpatient department or by referral. On admission to the ward the patient was interviewed by a ward when the psychiatric history and personal details were obtained; it was usual to meet the person accompanying the patient. Newly-admitted patients were introduced to the ward, its system, rules, facilities, other patients and other staff.

A primary basic nursing plan was drawn up for each individual patient. The Occupational Therapist also met with the patient and designed an individual programme suited to the patient's needs.

On the ward round this care plan was revised by the rest of the therapeutic team including the consultant, social worker, psychologist, other members of the nursing team, OT, dietitian etc. On many occasions patients were asked to attend these rounds for discussion of their therapeutic programme.

During the period of the study the system being used was that of the keyworker, each nurse working with a number of patients as their keyworker. This system was useful in developing a deep understanding of the patients from a holistic point of view and for a better identification of the patient's abilities, capabilities and disabilities. However it had the drawback of isolating the nursing staff from the other patients, which could cause them to lack necessary support in the absence of their personal keyworker.

The nursing staff on Ward 56 enjoyed a recognizable degree of autonomy and productivity. During the experimental phase of bridging therapy, the staff on Ward 56 managed to develop a number of therapeutic activities that were compatible with the concept of bridging therapy and continuity of care. These activities were as follows:

- a) Introduction of the "drop-in" policy, whereby even after discharge patients can drop in the ward, day or night, for therapeutic support
- b) The "Green Telephone", a means by which patients, after discharge, can ring the ward for help or advice directly without having to go through the switchboard. In some cases even wasting a few minutes going through the switchboard could have serious effects while the independent line gave a feeling of privacy

- c) Development of a policy by which nurses on the ward could voluntarily visit their discharged patients at the patient's home if support or assessment was needed
- d) Development of the "Post Discharge Group": this was a group of discharged patients and a number of the nursing staff from Ward 56 and a social worker who met every week for a social chat or just a cup of coffee, in Victoria Hall (a large church near the city centre with several storeys and a large number of rooms which can be used for different activities).

In connection with Ward 56 are the Day Hospital facilities and services. The range of activities was quite broad, covering simple fundamental skills like pottery, cooking and handicraft to quite intensive forms of group therapy like art projection, communication and psychodrama (details of these activities are given in Appendix 1).

iv) Medical Care

Patients had direct relation with their psychiatric consultants who admit patients to hospital. Each consultant oversees one or two of the medical staff who provide care on a daily basis. Each consultant saw his/her patients once a week on average, usually on an individual basis with his/her medical staff and nurse in charge. The length of interview was usually about 5-10 minutes, except in certain circumstances where patients needed more time. Exceptional interviews were also held on patient request. Weekly ward rounds were most important occasions when care plans were reviewed and decision making took place.

In the ward round people from different disciplines working in the ward met to discuss and review each individual case. On many occasions the patients concerned were asked to attend the discussion and participate in the decision-making. These meetings were held in a seminar room.

Admission, discharge and follow-up are the responsibility of the medical staff. Most patients receive chemotherapy, sometimes physical treatment if necessary.

There is no fixed limit to the length of patients' stay in hospital; however the trend is to encourage patients towards rapid recovery and ultimate independence. Nevertheless patients who needed longer periods of care (eg 6-9 months) were allowed to have such time for recovery provided that some recognisable improvement was continuing.

Some patients who were not able to make use of the services provided were transferred to other more specialised agencies like Middlewood Hospital, where there are wards for long term care; Phoenix House (a special institution for treatment of drug addiction); or the "Dry House", to deal with problems of alcoholism.

v) Nursing Care

As the nurses constitute the vast majority of the hospital staff, they were thus more closely involved with patients for most of the time. Besides their formal duties of observing patients, recording/reporting patient behaviour, participation in the care plan, ward rounds and OT activities, they were voluntarily participating in many of the other informal activities to provide/promote a friendly atmosphere on the

ward. For instance they joined patients in their outings to the swimming baths, bowling, cinemas, concerts etc. They tried to arrange discount tickets for patients, they encouraged patients to communicate with each other, play cards, or go to the pub for a soft drink and a chat.

This friendly atmosphere encouraged the patients to be more open about their problems with the nursing staff who had the experience to provide therapeutic help and support. Through guidance from the nurses some patients were able to discuss their problems with each other and gain the support of each other. This remarkable friendly attitude characterised the ward relationship.

vi) The Patients' Cultural Background

Patients participating in this project were not selected to represent specific cultural backgrounds. They were, in general, representative of the diverse cultural backgrounds of a Western industrialised city and they were subject to the different features that characterise such a metropolitan society.

As mentioned in Chapter One, one can observe that modern life dehumanises the person and values materialistic attitudes. Many of the patients encountered in the Psychiatric Unit of the Northern General Hospital, Sheffield, appeared to have been subjected to such problems, varying from disturbed family relationships, child abuse, lack of support from neighbours and friends, to loneliness of the elderly or general loneliness.

vii) Social and Material Support in the Community

The House of Commons Social Services Committee (1985) produced a report on community care of adult mentally ill and mentally handicapped people. In this report detailed figures were produced to show the wide variety of community services up to 1985. Very important examples of these are the development of facilities such as residential and Day Care centres; support group services; collaboration with voluntary organisations and housing associations. Although these services are not identical in every region of the UK, Sheffield represents a good example of the availability and variety of these services. In a more detailed description the following are found to be typical in Sheffield:

- a) A range of sheltered accommodation with different levels of independence; fully-or partly-staffed hostels, eg "Halfway Houses" or "Three-Quarter Way Houses"; and hostels for rehabilitation from alcohol or drug abuse.
- b) Day Centres for social readjustment, personal growth and friendship; a range of therapeutic, recreational and social activities are provided. Three are run by the local authority and one by a charity (MIND).
- c) A sheltered work scheme offers paid work in sheltered environments for up to one year. Work skills are taught and assistance is given to find a permanent job.
- d) Social Clubs - a variety of such clubs for people with mental health problems, mainly run by charity (MIND). There are also many other facilities available to the general public which are of special relevance to people with psychological problems.
- e) State income maintenance or invalidity benefit - a higher rate of unemployment allowance is paid to people who have permanent

handicaps and have been incapable of work for more than six months.

- f) Accommodation - a range of houses and flats is provided by the local authority.
- g) Leisure services - opportunities for recreation such as swimming, outdoor/indoor games etc.
- h) Education Services - adult education classes at different levels, both for courses of study and recreation classes, e.g., pottery.
- i) Other services provided by the NHS are available in the form of Outpatient Clinics, the Day Hospital, Community Psychiatric Nursing and care services.

The above description of the Mental Health Service generally in Sheffield, and particularly Ward 56, Northern General Hospital, reflects the efforts devoted towards the development of a 'comprehensive' service.

The following section will deal with a different setting, i.e., that of Cairo, Egypt, which unfortunately lies at the other end of the continuum where even basic services are difficult to provide.

The Cairo Setting

Cairo is the capital city of the Republic of Egypt. It is a very large, crowded industrial city with a population of 10 million. It is the centre of every feature of life in the country and because of this centralisation the population is increased by a workforce of an extra 2 million each day. In 1982 the total population of Egypt was 40 million, so more than a quarter of the population is concentrated on Cairo.

Despite some industrial features it has been highly modernised and is a tourist attraction. It is a very active city with many activities taking

place both day and night. What we consider as 'summer weather' lasts for three-quarters of the year.

In Egypt there are four large universities: Cairo, Ain Shams, El-Azher and Helwan. There is also the privately-run American University. There are many institutions of technology. Education in all these institutions (except the private one) is free.

Health care in Cairo is provided either by the state hospital run by the Ministry of Health or by the university hospitals. Private service in the health field is greatly advanced but very expensive; however, the tendency is to be treated privately if one can afford it.

With regard to the mental health service, there are two very large mental hospitals in Egypt, one in Cairo with a capacity of 3000 beds for both male and female patients and the other at El-Khanka, near Cairo, with 2000 beds but only for male patients. These two institutions were built two hundred years ago as horse stables and have since been transformed into mental institutions. They operate in a custodial manner, with no nursing staff in the male wards only male attendants. The situation is very much like the mental institutions in Britain in the Victorian era. However, occupational therapy is much encouraged, probably because it is economical to provide. There are other forms of mental health care provided at the district general hospital and university hospitals and health centres. Private practice provides a very wide range of service both in clinics and in hospital (Gawad 1981). The Egyptian health service system was considered in more detail in Chapter One.

i) The Hospital Community

The hospital of choice was El-Niel Sanatorium for Mental and Psychological Disorders, Cournish El-Niel, El Maadi, Cairo, Egypt. This is a private hospital, i.e., patients pay for the services received. This hospital was chosen to be the location of the study because:

- a) State hospitals are in a very deteriorated condition because of the lack of facilities as discussed in Chapter One. In that sense they are not typical representatives of the actual mental health service in Egypt.
- b) The types of disorders chosen for this study were to be either neuroses or mild psychoses.* These disorders can only be found in a private hospital, very rarely in a state hospital.
- c) The Director of the hospital agreed to this project being carried out in his hospital and with his patients. He also promised support and co-operation.
- d) The researcher was familiar with the hospital, its system, types of disorders and modes of treatment.

El-Niel Hospital is composed of three main departments in the three categories shown below:

* Patients with psychotic disorders, but whose symptoms don't interfere too strongly with their comprehension or ability to understand/participate in a conversation.

Table 4.1: Residential Categories in El-Niel Sanatorium

D E P A R T M E N T	Categories				
	Closed door wards	Male	1st class	2nd class	3rd class
	Closed door wards	Female	---	2nd class	3rd class
	Open doors	Male and Female	1st class	2nd class	---

The hospital bed capacity is about 180 beds, divided mainly between female and male wards and also between the three classes. There are about 50 beds in total devoted to female patients, about 5 of these beds are 1st class and in the open doors section only. For the male patients there are about 20 beds for the 1st class open doors section and also about 12 beds 1st class in the closed doors section. The remaining beds are mainly 2nd class with a few, about 20, 3rd class.

Hospital Rules:

Contrary to Ward 56, Northern General, Sheffield, El-Niel hospital has an institutional system relying heavily on a closed doors policy to ensure the safety of the patients and enforcing compliance with hospital orders and rules. Patients in closed door wards are usually dressed in indoor clothes (e.g., pyjamas or galabia), and are not allowed to leave the hospital or use the telephone without being accompanied. There are steel bars on all the windows and patients are not allowed to go onto the balcony except with permission from a doctor or nurse or unless accompanied by a member of staff or family.

However, there are a number of facilities which are provided in the

form of an open-air garden, with plenty of seats and tables; a mosque; a cafeteria selling drinks, sweets and crisps all day from 9am to 7 pm. There are colour TV sets and video recorders in every ward; facilities for table tennis, woodwork, painting and drawing, knitting and embroidery; keep fit programmes; some outdoor activities such as football in a nearby playground (this is only for patients allowed to go out with doctor's permission); or going to the cinema or for a day trip to visit different places of interest in Cairo. The hospital also provides daily newspapers and different magazines and there is a small lending library. Another important rule is that visiting hours are quite open, from 10.30 am to 5.30 pm with a one-hour lunch break at 1.00 pm.

Open-door wards are completely the opposite of closed-door wards. These patients can keep their own personal belongings and are allowed to dress in outdoor clothes and they have the freedom to go outside the hospital provided they inform the hospital administration. They can go for a holiday of up to one week and are allowed to spend a weekend or a few days during the week at home with their family. They also are free to use the telephone and to go on the balcony.

However, because of their freedom they are largely excluded from the indoor and outdoor activities arranged by the hospital staff, and only left with the TV and video facilities.

The 'classes' serve mainly to identify the category of payment; patients of all classes receive more or less equal services but there were differences in the type of room used, i.e., single room is first class; a room shared with one or two others is second class; and if

shared with more than two, third class. The first and second class rooms are nicely decorated and have new furniture and a daily change of bedding. The third class rooms are on the ground floor; less attractively decorated; have older furniture; and bedding is changed every other day, or as needed.

The cost of stay ranges between 5-10 Egyptian pounds per day, which is approximately £3-6 English pounds.* The cost includes a bed, three meals and all the hospital services. The cost of medication, clinical investigation and any extra specialised care, e.g., X-ray, dental care, was excluded. The psychiatrist or hospital administration makes the decision about admission to open or closed-door wards. Even though patients come voluntarily for admission, it is the hospital's decision to put him/her in a suitable ward. Other patients are admitted involuntarily or formally, i.e., sectioned according to the Egyptian Psychiatric Law in May 1941, and in this case referral is either by the family or a psychiatrist. Sectioned patients would be kept in closed wards. Some voluntary admitted patients are also kept in closed wards for their own safety.

Open-door wards are used for neurotic cases or mild psychosis, or chronic cases. The ward class is chosen by the patient, his family or the sponsoring body (e.g., work, or insurance agency). In some circumstances patients are admitted involuntarily for their safety, e.g., in case of violence or overdose; but have been considered

* Currency value of 1984.

voluntary in the official papers if the patient agrees to stay in the hospital for treatment and signs the papers.

ii) The Hospital Staff

The hospital is run by the director of the hospital who is a senior psychiatric consultant with a team of senior and junior psychiatrists and two general physicians to deal with medical problems arising among the patients. This medical team is considered the most important work force in the hospital and they are responsible for almost every individual patient from a holistic point of view, which includes psychological, social, medical and nursing care. There are seven members in the team in addition to the director. The director has a direct responsibility towards all patients admitted to the hospital and has indirect responsibility regarding patients admitted and detained under external psychiatric supervision. The rest of the medical team have a direct responsibility towards all patients in the hospital assigned to them.

The nursing staff are unqualified personnel with a varied experience (2-15 years). Their duties are to give daily medication; keep patient records; ensure safety and keep appropriate cases under close observation. They are also responsible for patients' and ward cleanliness and supervise the distribution of meals. The most important duty is to keep the door closed in a closed-door ward.

Auxiliary staff play a very important role in controlling patients' violent behaviour, cleaning the hospital and guarding the patients and the wards. Their role is vital to prevent patients from committing suicide, from escaping, damaging hospital property or behaving

aggressively towards each other and towards the hospital staff, especially the nurses.

iii) Medical Care

In El-Niel Hospital the medical staff are responsible for each patient in all aspects, whether medical, psychological, nursing care or social welfare. The medical staff is responsible for admitting the patients but the discharge procedure is usually controlled by the hospital director.

Patients' treatment is mainly chemical and physical therapy; psychotherapy is very limited in use, there being only one group for addicts and another for ward meetings. However, the informal psychological support provided by the medical staff by means of a friendly chat or problem-solving discussion is usually of great help for patients to express their feelings and listen to advice. The closed-ward policy has forced patients to interact with each other and support each other.

The medical staff (Junior Psychiatrists) are responsible for each individual patient in the hospital and employ the key worker system, which is the system of specified workers being responsible for a certain number of patients from all aspects, ie prescribing medication; assessing; observing; recording and monitoring changes. All the therapeutic interventions, including necessary medical care or investigation, are carried out by the medical staff. They also supervise the occupational therapy given to patients in terms of which activity is assigned to which patient. They work only morning shifts, ie from 8-9am -2-3pm, as afternoons and nights are covered by

the resident doctor in charge.

iv) Nursing Care

Staff working on the wards at El-Niel Hospital, apart from one general nurse, do not hold nursing qualifications, although they are known as nurses. There are 25 staff working 3 shifts, mainly morning and afternoons, as night shifts are usually covered by just one or two nurses for the whole hospital.

Their work is to distribute medication and supervise patients taking it; observe and control patients with unacceptable behaviour; and report this to the hospital resident doctor. They must ensure patients' cleanliness and that of the ward. They provide informal psychological support for the patient by discussing problems with the patient, the family and supporting him/her during periods of distress. The auxiliary staff also play an important role in caring for the patients.

There are no male nurses in Egypt; most of the physical care for male patients is attended to by male auxiliaries, who control aggressive behaviour, and take male patients on trips and outings in addition to implementing occupational therapy activities.

v) The Patients' Cultural Background

There are no unique features in the cultural backgrounds of the patients at the El Niel Hospital. They come from upper and lower Egypt and other parts of the Arab world. They had a varied range of income, education, type of work, religion and social class, ranging from working class to aristocratic. An important feature of Egyptian society today is that one's economic level does not necessarily correspond with

one's social class; for example a worker in a profitable company could be better off financially than a lecturer in a university. The majority of patients are of the Islamic religion and there is also a group of Christians. Both Moslem and Christian patients believe in God but only a few of them observe their religious rules; they are inclined to observe traditional and cultural rules and observe these norms/morals, eg one patient would not pray or stop smoking cannabis, or cigarettes, or being rude to strangers but in his father's presence he would behave politely. .

As previously discussed in Chapter One, family relationships are still close, providing great care and support for each member, who try to live within a short distance of each other and young adults, of either sex, do not leave home except to get married. This means that quite often there are three generations living in one house. It is quite acceptable to discuss love relationships and emotional involvements with friends and relatives but can be very difficult with parents and immediate family members. .

Egyptian society has seen massive immigration from the rural to the urban areas over the last 30 years; and in particular to the larger cities with the majority concentrated in Cairo, resulting in the establishment of new communities of homogeneous groups of friends and relatives and extended families. The people in these new communities do not leave their traditions and morals behind but, on the contrary, establish them in their new society and an increase in their income does not mean a change of social class.

vi) Social and Material Support in the Community in Egypt

There are no specific community services provided for mentally ill patients after discharge. Follow-up treatment is carried out by doctors in the out-patient clinics or in private clinics. No community psychiatric nursing care is available and social workers limit their duties to the office and to dealing with financial affairs. However, any patient in need of psychiatric care is seen on the same day and, if necessary, admitted to hospital as there are no waiting lists. The family is a close unit and its members are responsible for looking after the patient all the time, and providing support, care and love all the more during hospitalisation to reassure the patient that he/she is still wanted. On the few occasions when the patient is highly disruptive or chronic and has made very little progress, the family may experience difficulty in coping and may seek to place the patient in one of the large state mental hospitals.

Government policy to help patients in the community is the possibility that patients with permanent disability (including previous mental illness) could keep their jobs with fewer duties and flexible hours. Large companies also are encouraged to employ disabled people (up to 6% of the workforce).

The social and material support as provided in Britain is non-existent in Egypt. The psychiatric service in Egypt lies mainly in medical care either inside or outside the hospital. Professor Gawad of Cairo University revealed, in 1981, the following figures regarding the service in Egypt. He explained that in the early 1960s a decentralisation of health care was implemented to provide a psychiatric service in small hospitals, in the in-patient units of

district hospitals and in out-patient clinics of approximately one psychiatrist for every 200,000 people and one bed for every 6000 people. Free service is provided in 52 out-patient clinics, 31 in-patient psychiatric units and 3 mental hospitals. Other forms of psychiatric hospital-like day hospitals and night hospitals are non-existent and a serious disparity still exists between urban and rural psychiatry. There are no specific facilities provided for after-care of mentally ill patients in the community.

4.2.2.2 The Two Phases of the Study

Three years were allocated to carry out the study and this time was divided unequally between Sheffield and Cairo.

Phase One: Sheffield October 1982 - September 1984

- a) The first stage: this was preparatory, for nearly six months, where the researcher was becoming acquainted with the environment; the work with psychiatric patients in a British hospital and community; joining a team of community psychiatric nurses (CPNs) and paying visits to patients at home and at work. The researcher also joined the Occupational Therapy team in the day hospital at the Northern General Hospital and participated in different group therapies and other activities taking place such as outings and hospital parties. It was hoped that this stage would enable the researcher to be accepted by patients as a natural member of the staff rather than an external person. This was also intended to minimise the halo effect and/or contamination of the experimental field.

During this stage the researcher was also studying the existing service for the mentally ill in Sheffield. The orientation phase revealed the

structural differences in the community health care provided in Sheffield. Community psychiatric nursing was provided only for patients referred by a GP or psychiatrist. Patients who were admitted to hospital for whatever reason were discontinued from the care of the CPNs whilst in hospital. CPN's therapeutic intervention was devoted to symptomatic problems or specific neurotic problems eg agoraphobia or giving injections - very little was observed in terms of family/marital therapy or teaching. No specific programmes were designed for each individual patient, it was mainly purely nursing based on employment of specific nursing skills with very little communication with other disciplines or comprehensive team work.

The researcher believed that finding a link between the hospital service and the CPN service could be achieved and could lead to the development of a new comprehensive service where there is continuation of care started in the hospital into the community. This system was supported by Kirkpatrick (1967) and Greene (1968).

Therefore the approach studied was given the name bridging therapy (to provide a type of therapy that would bridge the gap between hospital care and community).

b) The second stage: this was for the data collection process

The lack of assessment instruments that would be helpful to evaluate the patients' conditions in scientific terms was recognised. Therefore this stage saw the development of such an instrument, the Behavioural Adjustment Inventory (BAI 100 items scale) and the Recovery Index (RI). Selection of patients took place according to specified criteria, and methods of selection described later under the sampling strategies.

Using semi-participant observation, in-depth interviewing as well as implementation of the BAI 100-item scale and its RI took place; also the General Health Questionnaire (GHQ) and Eysenck Personality Inventory (EPI) were all employed for data collection.

This was the longest stage and took fifteen months during which time the eleven participants were chosen, received a bridging therapy programme and evaluation of their condition took place.

Patients were assessed using the BAI, RI, GHQ and EPI on admission. On discharge from hospital and at the end of the follow-up period, the RI, and GHQ were used. Details of these methods are discussed later under methods of data collection. Selection of the control group was subsequent to the selection of the experimental group.

Through this stage problems encountered with the implementation of the BAI and its RI were identified and the need to improve their efficiency was recognised. The data collection for the Sheffield sample had to be completed using the original version of the BAI₁₀₀ item scale and its RI because the assessment of the experimental group had already been completed and that of the control group was near the end.

- c) The third stage: This was devoted mainly to improving the validity of the BAI and RI. Steps to increase their efficiency are discussed in detail under the section on the development of the BAI.

The first phase was looked on as a learning, preparatory phase for the one to follow in Cairo, so that similar problems could be avoided and

so help the validity of the study.

Phase Two: Cairo September 1984 - February 1985

Again, two groups of patients were selected using the same principles. Here bridging therapy was employed in two ways: first, by introducing the concept of community psychiatric nursing care to Egyptian society, which totally lacked such experience; second, to test the effectiveness of the bridging therapy in a different cultural context. Many of the previous problems encountered in the Sheffield phase were eliminated in the Cairo phase; this was mainly because of the experience gained and the practicability of the new, modified version of the BAI₃₀ item scale.

However, other problems were encountered which to some extent impeded the course of the study. Fortunately, with a few modifications in terms of patient numbers and period of follow-up, the study was continued and was completed within the fixed time. Although the Cairo stage was fairly short (six months) enough data was collected to enable a reasonable comparison to be made with the Sheffield groups.

4.3 Methods of Data Collection

The period of data collection constituted the main bulk of the work and occupied nearly three-quarters of the time allocated to the project. The previously-mentioned structured instruments, namely GHQ, EPI and BAI, were employed for data collection together with semi-participant observation methods, anecdotal records and semi structured interviews. Audiotapes were used in a few instances. The qualitative data are presented in this study as case studies which reflect the richness of this information and its importance for subsequent examination of the results.

The official method for data collection began by inviting patients in each group (experimental and control, both in Sheffield and in Cairo) to fill in the questionnaire forms of the GHQ and the EPI.

(Translated copies were given to Cairo patients details of which can be located in a later part of this chapter.) The BAI scale was filled in by the researcher and the consultant psychiatrist.

In Sheffield the measurement of health status was through the use of RI, and assessment was done separately by both the researcher and the consultant. In Cairo the BAI₃₀ item scale assessment was done jointly by the consultant and the researcher. No translated version of the BAI₃₀ was needed in Cairo as both the researcher and consultant psychiatrist speak English fluently. Re-evaluation of Sheffield patients has been done using the same procedure as that used in Cairo. The re-evaluation was done retrospectively using the information provided by the original assessment from the BAI₁₀₀ item scale, RI and the anecdotal records. This time, joint assessment (i.e., researcher with the consultant) was employed and this proved very effective as it ensured consistency of rating, reduced the risk of inter-rater lack of reliability and resulted in satisfactory agreement between the two raters.

Assessment of patients using these instruments was to be done on three occasions: on admission to hospital; on discharge from hospital; and after the termination of the follow-up phase, ie three to six months post-hospital discharge. Therapeutically speaking, in-depth interviewing in the form of semistructured and unstructured interviews, individual or group therapeutic sessions, and semi-participant observation were used to implement bridging therapy and test its effectiveness.

The previously mentioned plan for employing methodological mix (quasi-experiment and action research) was implemented for data collection. This was achieved through the following strategies.

4.3.1 Semi-participant Observation

Semi-participant observation (in the sense defined earlier) occupied the majority of the time spent working with patients in the hospital. The researcher participated as a member of the hospital staff taking part in all types of activities arranged for the patients; in other words, the researcher joined in the ward rounds and ward meetings; recorded observations; provided therapeutic help for patients on the ward in general (not only limited to the experimental group); participated in indoor and outdoor activities, and in different group therapy sessions in the Day Hospital on a regular daily basis.

Semi-participant observation techniques helped the researcher to keep realistic notes about the experimental group in various settings and in writing-up case studies. This was practised more in Sheffield than in Cairo because the range of activities in Sheffield was far greater than that in Cairo. Participation in the Cairo situation was limited to ward rounds; one type of group therapy; one type of ward meeting and a few outdoor trips. Patients spent most of their time watching TV, playing cards or chatting to each other. The visiting hours were the most prominent feature of their day, when they spent two hours in the morning and two hours in the afternoon with their families.

Despite the value and richness of the information gained through the implementation of this technique, the researcher found it to be very difficult and impractical for short-term research studies. Problems

encountered during the implementation of this technique are summarised as follows:

- 1 **Time Constraints:** participation as a member of staff working both within and outside the hospital, occupied a ten or twelve-hour day, five days a week for two-and-half years. It is not possible in human and economic terms to set up this impractical example of service either for patients or for the researchers involved.
- 2 **Information Wastage:** the deep involvement in the patient's life, both during hospitalisation and after discharge, led to the accumulation of a vast amount of personal data concerning the experimental group. Considering that only a limited number of case studies could be included, much qualitative information regarding other patients in the experimental group could not be directly used.
- 3 **Selectivity:** this inherent limitation of observation technique could have influenced the researcher's judgement of different situations. Nevertheless the use of anecdotal records and hospital files and specialists' notes helped to reduce this possibility.
- 4 **Researcher Bias in Data Collection:** semi-participant observation can be relatively easily performed in a setting where observation of all participants is of equal importance. In the current study the researcher tried to limit participation to patients in the experimental group. This proved impossible as every therapeutic activity on the ward or the day hospital included all patients on the ward. Consequently, participation with patients in the control group was inevitable. In addition, two patients in the control group requested to

receive bridging therapy and community follow-up. Therefore the decision was made to select the control group after completion of the experimental phase of bridging therapy in the Sheffield setting.

4.3.2 In-depth-Interviews

Interviews were both semi-structured and unstructured in nature. In this study the semistructured ones were conducted on three occasions: on admission to hospital; on discharge; and at the termination of the follow-up period. This method was used both with the experimental and control groups. The main purpose of these interviews was to facilitate completion of the BAI and encourage the patients to complete the psychometric questionnaires.

The unstructured interviews were conducted for therapeutic purposes, including implementation of bridging therapy and FIA. The unstructured interviews were essential because in these sessions, patients' problems were identified and a plan of work was designed, implemented and evaluated for evidence of progress, or other changes. These interviews were held both on an individual and a group basis. That is, sessions were held with patients on their own (individual); or with patients and their families; or with their families alone; or with a number of staff members and the researcher together with the patient and/or his/her family.

The flexibility of this approach was of great value both for the patients and for the researcher, since many therapeutic outcomes and much qualitative information was obtained by its means. Co-operation of the other members of staff, including consultants, nursing staff, social workers and occupational therapists, proved most effective for purposes of

planning and intervention.

Such therapeutic interviews were only provided for patients in the experimental group, since they constituted an important element of bridging therapy. Data obtained during in-depth interviews was recorded either on the spot, or soon after the session, as appropriate. The few audiotaped interviews proved to be of great help to the researcher. However patients generally did not like the idea of having their conversations audiotaped.

At the time of assessment in-depth semi-structured interviews were utilised to explore and examine the patient's condition in relation to the items of the assessment instrument (BAI). These proved to be most difficult, especially on the second and third occasions, i.e. on discharge and post-discharge, as patients were more spontaneous in their interaction with the researcher, tending to side-step formalised discussions. On many occasions a single interview session would take up to three hours, especially in the Egyptian context, where patients were talking about many side-issues that were not necessarily relevant to the study or to the assessment inventory. As a technique in-depth interviewing proved much more difficult than the researcher expected, due to its time-consuming nature; difficulties engendered by the need to record data on the spot without stopping the flow of conversation; and patients' refusal to be audiotaped. As a result some information was inevitably lost.

Nonetheless, the main objectives of these interviews were achieved, since patients' conditions were assessed; supportive data was gathered by interviewing patients' families; reflections of patients' attitudes and personalities were obtained; by these means appropriate

psychotherapeutic interventions were provided.

4.3.3 Self-Report Questionnaires

In addition to the previous two methods of data collection psychiatric questionnaires were used to ensure the consistency of judgement between patients, the researcher and the consultants.

The questionnaires chosen for this purpose were the General Health Questionnaire (GHQ) by Goldberg (1978); and the Eysenck Personality Inventory (EPI) by Eysenck and Eysenck (1963). These two instruments are considered in more detail in a later section of this chapter. These questionnaires were obtainable in a standardised form in both English and Arabic. It was assumed that the use of questionnaires in addition to semi-participant observation and indepth interviewing would help in the following:

- 1 Exploration of the patients' views about their problems and health conditions.
- 2 Comparison of the consistency of patients' responses with those obtained using the BAI.
- 3 It was hoped that, by filling-in these questionnaires, patients would begin to feel some formal obligation towards active participation in the project. For this reason, patients were invited to fill-in the questionnaires as soon as they agreed to participate in the project. Nevertheless, filling-in the questionnaires sometimes appeared to present difficulties for some patients. For example, some patients

had difficulty reading the questions because of blurred vision (side effect of a major tranquilliser); and others could not read properly, as with some members of the Egyptian sample. Some of the questions appeared to be obscure, whether in Arabic or English: and some explanation had to be provided. Some patients had to be 'chivvied' to get back the completed questionnaires; whilst others complained of the long, boring questionnaires.

Despite these difficulties, patients in both groups in the two countries, managed to fill in the questionnaires required.

It was intended that all patient groups should complete the GHQ and the EPI on three occasions. This proved very difficult; and the plan was changed to completion of the EPI on admission only, whilst the GHQ was completed on three occasions.

4.3.4 Checklists; The Behavioural Adjustment Inventory, (BAI), and its Recovery Index, (RI)

The BAI is a checklist developed to provide a frame of reference for both the semi-participant observation and the semi-structured interviewing. In addition, a Recovery Index (RI) was also produced to provide a scale of measurement of the problematic areas identified by the items included in the BAI.

The decision to develop this instrument was crucial for a number of reasons:

- 1 Quasi-experimentation requires assessment and evaluation of the programme under testing.

- 2 The current design of this research used a methodological mix approach which included qualitative as well as quantitative evaluations.
- 3 Validity of the information obtained needed to be ensured.
- 4 As action research requires team work, it appeared useful to employ an assessment instrument that could be used by various disciplines to assess a general psychiatric condition, in a multi-context (hospital/community) and multi-cultural (British and Egyptian) setting.
- 5 An extensive literature search made it clear that such an instrument was simply not available. Lack of such an instrument left the option for the researcher either to abandon the whole project or to adopt the pragmatic solution of attempting to develop an innovative instrument to be validated during the course of the work.

In response to Miller's (1981) call to develop a community nursing assessment instrument that follows the holistic approach, the decision was taken to develop, validate and implement the BAI. Details of the validation procedure appear in a separate section of this chapter.

4.3.5 Data Collection Instruments

In Sheffield:

Three instruments were employed for this purpose, namely the Eysenck Personality Inventory (EPI) General Health Questionnaire (GHQ), and the Behavioural Adjustment Inventory (BAI).

1. The Eysenck Personality Inventory (EPI) (Eysenck H J and Eysenck S B G 1963) (Appendix 2)

The EPI is like its parent instrument, the Maudsley Personality

Inventory (MPI) (Eysenck 1959). It was designed to measure two major dimensions of personality, extraversion/introversion and neuroticism. Eysenck claimed that the EPI is very similar to the MPI but more useful for the following reasons:

- a) The EPI consists of two parallel forms making retesting possible without interference. EPI Form A was the one used in the current research.
- b) The EPI has been carefully reworded so as to make it more easily understood.
- c) It contains a Lie Scale.
- d) It is more reliable than the MPI.
- e) It is a valid instrument descriptive of the behavioural manifestation of personality.

Because of the previously-mentioned reasons, it became quite clear that the implementation of the EPI would be useful as a self-report instrument and to compare its results with the BAI results.

2. The General Health Questionnaire (GHQ) (Goldberg D 1978) (Appendix 3)

The GHQ is a self-administered screening test initially designed to detect psychiatric disorders among respondents in community settings, such as primary health care, or among general medical outpatients. As such, it focuses on breaks in normal function evidenced by two classes of phenomena:

- i) inability to continue to carry out one's normal 'healthy' functions
- ii) the appearance of new phenomena of a distressing nature.

No theoretical assumptions are made about the nature of 'hierarchies' within the class of psychiatric illnesses: only that there are less differentiated ways in which all such patients differ from those who are 'well'. The theory is thus consistent with any of the numerous hierarchical models proposed by workers as diverse as eclectic psychiatrists (Gruenberg, 1969; Wing, 1976); biostatisticians (Maxwell, 1973); clinical psychologists (Foulds and Bedford, 1975); and psychoanalysts (Meninger, Mayman and Pruyser, 1963). The result is a sixty-item, Likert-type scale measuring six principal factors concerned with personal perceptions; general illness; somatic symptoms; sleep disturbance; social dysfunction; anxiety and dysphoria and depressive symptoms (Goldberg and Hillier, 1979). Parallel forms exist and the test is generalisable as a monitoring device for administration before, during and after specific therapeutic intervention; when it functions as a subjective index of recovery from morbid states. Together with the EPI, it is included in the present study as a subjective complement for comparison with observational evidence of recovery status obtained by means of the Behavioural Adjustment Inventory (see below).

3 The Behavioural Adjustment Inventory (BAI) (Appendix 4)

This is an observational checklist to assess the patient's behavioural adjustment or maladjustment. Details of its development and validation are given in a later section.

In Cairo:

Instruments of data collection in Cairo were the equivalent Arabic versions of both the Eysenck Personality Questionnaire (EPQ) and the General Health questionnaire (GHQ₃₀); plus the English version of the Behavioural

Adjustment Inventory (BAI₃₀). No Arabic translation was needed for the BAI₃₀

- 1 The Eysenck Personality Questionnaire EPQ₃₀ (Arabic version, Appendix 14).

Abed El-Khalek and Eysenck (1983) carried out a cross-cultural study of personality between Egypt and Britain that measures psychoticism, extraversion, neuroticism and social desirability. They translated the 101-item version of the EPQ (Eysenck and Eysenck 1975) into Arabic and it was completed by 641 Egyptian males and 689 females. The sample included different groups, e.g., nurses, doctors, housewives, and technicians etc. The Egyptian data was analysed in the same way as the British data. Factor analysis gave reasonably high loadings for each of the factors except for psychoticism. However, factor comparison calculated after the method described in Eysenck and Eysenck (1969) indicated identical results with those in Britain.

There were few problems in the factor loadings e.g. Item 5 "Are you a talkative person?" and Item 70 "Do you often take on more activities than you have time for?" failed to load on 'E' in but loaded on L and N respectively. However Item 88 "Do you sometimes like teasing animals?" gained loadings on 'E', suggesting that Egyptian attitudes to animals are less sentimental than in Britain, with "teasing" coming into the realm of sport.

Neuroticism was also relatively straightforward, with three weak items that were dropped from the scale, number 20 "Are your feelings easily hurt?", number 52 "Do you worry about your health?" and number 98 "Are you touchy about some things". It was decided to

substitute three other items that gave good loadings on 'N', namely Item 48 "Do you feel self-pity now and again?", Item 56 "Do you sometimes sulk?" and Item 70 "Do you take on more activities than you have time for?" The 'L' scale lost two weak items, namely number 17 "Have you ever blamed someone for doing something you know was really your fault?" and number 80 "Have you ever insisted on having your own way?". The 'P' scale loadings were considered weak throughout, especially for females. Extensive modifications were undertaken to exclude compromised items. Originally the scale was 33 items; after these modifications it is now 26 items.

Generally speaking the instrument has reasonably high reliabilities except for the 'P' scale. These findings show high similarities between Egyptian and British respondents, regarding 'E', 'N' and 'L' scales. The authors assume that many items of the 'P' scale are inapplicable in the Egyptian outline. They recommended the use of the EPQ in Egypt but with great caution with respect to the 'P' scale. In the current study, items loading on the 'P' scale were excluded to avoid such problems.

2 The General Health Questionnaire GHQ₃₀ (Arabic Version)

Professor Fakhr El-Islam, Kuwait University, has produced the Arabic version of the GHQ₃₀ for research purposes. In a recent communication with the researcher, he explained that the instrument is not published, but permission for its use was obtained from its British authors, i.e. Goldberg and Hillier (1979). A recent published work about inter-generational conflict and psychiatric symptoms (El-Islam 1986) has described briefly the process of its development. He found that it was necessary to modify the form and the style of the British test, before it could be applied to Arabs, e.g., items which did

not translate well had to be rephrased to convey the meaning in common Arabic parlance.

Both the EPQ and the GHQ were administered to both the experimental group and the control group on admission to hospital. Patients in both groups completed the GHQ on admission, discharge and post-discharge. The questionnaires were completed in the presence of the researcher to ensure as little loss of data as possible. An explanation of instructions and statements was conducted by the researcher for each individual patient in both groups prior to data-collection. For illiterate patients, the researcher had to read the questions and mark the answers. On some occasions clarification of a number of statements was also provided.

On the whole patients were able to participate without major complaints, However, not every one of them appeared to be particularly interested in the content of the questionnaire.

These technicalities of administering, modifying, translating concepts rather than words, are comparable with the earlier discussion in the introductory chapter regarding Leff (1973) and Orley et al (1979) in respect of experiments and recommendations.

4.3.6 Development of the Behavioural Adjustment Inventory (BAI)

1 Main Purposes of the BAI

The Behavioural Adjustment Inventory (BAI) is a guiding instrument for the assessment of adjusting behaviour of adult psychiatric patients, intended for use both in hospital and community treatment contexts. It was developed to provide reliable data concerning the patient's health

status expressed in numerical form. This ideal quantitative description can never be completely attainable due to the well-known difficulties of accurately defining and measuring such complex and frequently abstract concepts and associated phenomena. Therefore it has always been kept in mind that it must be allowable to use clinical judgement during assessment sessions - a method recommended by Wing et al (1974). Standardisation of the BAI has involved extensive procedures to ensure acceptable levels both of validity and inter-rater reliability. Details are set out later in this section.

A number of factors indicated the necessity of following this approach. Firstly, bridging therapy as evaluation research requires that the researcher become oriented to tasks based on "decisions" and "applications" rather than "conclusions"; on "applications" rather than "implications"; and on "utilisation" rather than "replication" (Windle and Neigher, 1978). Secondly, outcome evaluation generally seeks to determine the degree of patient improvement attributable to programme intervention (Coursey, 1977).

It was therefore necessary to operationalise the measurement of changes that could be regarded as attributable to the therapeutic effects of bridging therapy. Such an instrument would need

- (i) to assess a patient's healthy performance and/or the degree of deviation from such performance in both hospital and community contexts;
- (ii) to be suitable for use by different disciplines, including psychiatrists, psychiatric nurses, CPNs and social workers - i.e., to correspond with the requirements of multidisciplinary care;
- (iii) to use a "common currency" of recognisable, universal human

health behaviour so that it could be implemented cross-culturally.

Following a detailed computer search carried out in 1982 at the outset of the study, it became clear that such an instrument was currently unavailable and would need to be developed.

4.3.6.2 Theoretical Background of the BAI

The literature review indicated that the need to develop an instrument for the assessment of patients' mental health was recognised as early as the nineteenth century. Downing and Brockington (1978) found that observational charts and assessment instruments have been developing fast since the late 1960s; but these attempts are constrained by many problems including, e.g., internal validity; inter-rater reliability; contexts of implementation and scoring scales. Furthermore, many such assessment instruments focused on clinical and pathological aspects of patient behaviour; and were criticised for their fragmented perception of patients' problems (Downing and Brockington, 1978).

Workers such as Clare and Cairns (1978) and Brooker (1984b) tried to produce valid instruments in the form of rating scales that could be used to measure patient outcomes in the community, focusing on areas of dysfunction and social maladjustment. Again, many problems regarding inter-rater reliability and control of dependent and confounding variables were encountered and acknowledged by these workers.

The current status of patient outcome measures indicated the urgent need to follow a somewhat different approach to the construction of a suitable instrument. The BAI represents an innovative strategy in this respect. Previous attempts have so far focused their attention on the "objective"

determination of what is "abnormal" in a patient's behaviour. In the comprehensive work carried out by Wing et al (1974) in developing the Present State Examination (PSE), the authors acknowledge the limitation imposed by using "abnormal" behaviour as the criterion for assessment. For example, they found the central rule adopted by the PSE, that the symptom must be definitely present, made rating only possible during an acute attack of illness: but very difficult with fairly mild psychotic or neurotic conditions. A further limitation was that the PSE disregarded social factors when making such clinical decisions.

By contrast, the BAI attempts to focus on descriptive formulations of health states - especially on the healthy manifestation of various personal and social attitudes and adjustments - and on varying degrees of deviation from these described features. The major problem with this strategy is the perennial debate concerning the nature of "health". Thus the concept of health is subjective within a society; and varies considerably between countries, especially between countries in the developed and the developing world (Ewles and Semnett, 1985). Numerous attempts to define health have been only partially successful, including that of the World Health Organisation (WHO, 1948 & 1978); which sees health as

".....a state of complete physical, mental and social well-being, rather than solely an absence of disease.....a fundamental human right."

This definition by the WHO encountered a number of criticisms concerning its rigidity and inability adequately to account for the complex components of health and the dynamic nature of living (Ewles and Semnett, 1985). A more informative definition is to be found in the writings of Murray and Zeater (1970), who regard health as

".....a purposeful, adaptive response - physically, mentally and socially - to internal and external stimuli in order to maintain stability and comfort."
(Murray and Zeater, 1970)

In accordance with Murray and Zeater's definition, bridging therapy accepts that all health aspects are both inter-related and inter-dependent. Thus the following suggested definition of "health" is that upon which the essential components of BAI structure have been formulated:

Health may be regarded as a continuum of equilibrium of the individual within his/her immediate and interrelated contexts, incorporating dimensions of physical, cognitive, emotional, spiritual and social well-being.

This holistic stance provided an extremely useful guide to areas of assessment needing to be included within the eventual structure of the BAI.

4.3.6.3 Structural Components of the BAI

In accordance with the previous definition, four areas of assessment were chosen to constitute the structure of the BAI. These included communication and social skills; insight; self and family care; work and recreative activities. The diversity of these areas is illustrative of the eclectic nature of psychiatric nursing as a practical activity, drawing upon various theoretical accounts of human behaviour (Hirst, 1965; Irving, 1983).

For example, in the first area of evaluation, the statements used in assessment are predominantly of the "social skills" type; and may be analysed in terms of that theory. Detailed items concerning social skills and personal relationships were guided by the work of Jourard (1963); Weitz (1974); Argyle (1975); Goldstein et al (1976); and Trower et al (1978),

whose texts provide comprehensive illustrations of adaptive elements of social behaviour within the governing rules of specific situations; and by the work of other psychometricians working in the field of psychiatry, who have shown considerable interest in the processes by which interpersonal relationships are established (cf, e.g., Goldberg and Stanitis, 1977).

The second area of assessment - that of insight - was concerned with the individual's cognitive-subjective constructions of his/her reality. These were examined in relation to the eclectic perspectives provided by cognitive-behavioural, psychodynamic and phenomenological theory. Guidance for the compilation of cognitive-behavioural items was found in the work of Meichenbaum (1972, 1977); Kazdin and Wilcoxin (1976); and Kendall and Hollon (1981). Guidance for the compilation of psychodynamic items occurred in the work of Brenner (1973) and Storr (1979). Finally formulation of phenomenological items was guided by approaches occurring in the work of Esterson (1970) and Misiak and Sexton (1974).

The third area of assessment - self and family care - was concerned with personal hygiene; other aspects of self-care; care for other family members; family relationships. Guidance for the compilation of these items was found in the work of Levin et al (1977) and Leff (1982) respectively, concerning each of these aspects.

The fourth and final area of assessment - work and recreative activity - was considered specifically in relation to the individual's social role: and therefore paid work was not necessarily a feature, but those constructive activities with which a wide range of persons could identify were included. For purposes of BAI assessment, both the facts and processes of behaviour

are most frequently construed and described according to the models provided either by "social skills" theory, or by cognitive-behavioural theory, as appears most appropriate, bearing in mind the nature of the phenomena under study.

4 Technical Development of the BAI

Technical development of the instrument took place in two phases: the initial phase and the validation phase.

Initial Phase

During this phase a series of detailed discussions took place involving the researcher, her supervisor, and members of the 1982-83 community psychiatric nursing course in the Department of Health Studies, Sheffield City Polytechnic. The course members included 22 experienced psychiatric nurses, possessing a mean qualified experience in psychiatric nursing of ten years. In accordance with the theoretical frame of reference for the BAI described above, a pool of items of mainly observable behaviours related to healthy psychological adjustment to everyday living, were identified by this group of CPNs. These items were then referred to a small team of subject experts in the areas of psychology, sociology, psychiatric nursing and community psychiatric nursing, in order to refine them and to eliminate superficial or repetitive items, employing the methods of consensus and face validity. This procedure resulted in acceptance of 100 items to be included in the inventory. These were divided as follows:

SECTION A: Communication and Social Skills	30 items
SECTION B: Insight	20 items

SECTION C: Self and Family Care	30 items
SECTION D: Work and Recreative Activity	<u>20 items</u>
TOTAL:	<u>100 items</u>

Pilot Study

The developed BAI items were assessed in a small preliminary pilot study. Fifteen experienced CPNs working in the community as members of various regional community psychiatric nursing teams were requested to use the instrument for assessing one of their patients in the community. A procedure manual explaining each item, its situational assessment and criteria was developed by Dr Val Reed to be used in combination with the BAI₁₀₀ item assessment forms (Appendix 2). Both the BAI forms and manual were mailed to the CPNs two weeks in advance, so that they would have enough time to read and comprehend the procedure. They were also asked to write their comments, record the time spent in completing the forms and any suggestions for improvement. They were asked to request any further information if needed for understanding the BAI and the manual. A parallel test of the BAI in hospital was undertaken by three staff nurses and the researcher. For a description of the background of participants see Appendix 8.

All fifteen CPNs participated in the process voluntarily. They had attained a reasonable period of professional experience in psychiatric nursing (4-15 years) with a mean of 9 years. Their jobs were situated in nine areas ranging from Leeds to South Lincolnshire.

Pilot Study Outcomes

All fifteen CPNs sent in their completed BAI₁₀₀ forms with a number of comments and suggestions. In general they found the BAI and manual

helpful in:

- (a) making a comprehensive assessment more easily
- (b) looking at patients in depth and making changes in the assessor's pattern of dealing with these problems
- (c) forming a continuous assessment on a regular basis.

However, there were also some criticisms, such as:

- (a) Section D is only observable clearly in the actual work situation
- (b) the need to avoid referring to the manual during the assessment and the need for the assessment to be discrete and the difficulty of its continuity
- (c) certain items, eg 24 and 72, were inappropriate or difficult to assess
- (d) length of time taken on the assessment (ranged from 45 minutes to 480 minutes, mean 144.6 minutes).

The staff nurse in the hospital considered it useful but too long, with too much detail and sometimes evaluation was considered to be difficult on certain items.

Despite the criticisms noted by some of the assessors in the pilot study, the instrument was considered generally acceptable as the number of criticisms was small and as the instrument had been designed specifically to serve the purposes of the study. Some modifications were added to the instrument to eliminate the ambiguity experienced with Items 29, 46, 50 and 55 (Appendix 9).

4.3.6.5 Development of the Recovery Index (RI) (Appendix 5)

At the commencement of implementing the BAI as an instrument to assess patients contributing to this study, it became clear that a two-point

scale of measurement was not going to be suitable. Decisions about the presence or absence of items were often difficult and unrealistic to obtain; intermediate levels of functioning were recognised as being essential so that progress or regression could be recorded.

A "recovery index" on a five-point scale was developed by the researcher to be used in conjunction with the BAI₁₀₀ item scale. The recovery index consisted of statements covering the three intermediate levels of functioning; thus each item of the BAI₁₀₀ items was detailed to five subdivisions, amounting to 500 functioning levels (Appendix 5). The Recovery Index was used in combination with the BAI₁₀₀.

It will be noted that the original BAI items are not in themselves scalar; but constitute a set of propositions each representing the 'optimal' situation for that item. Following careful discussion with the patient, his/her family and members of the therapeutic team, the nurse-therapist identifies 'priority' items for that patient from among the items circled 'N' (for 'no'). Such items are then analysed in greater depth in order that a sequentially-structured 'scale of recovery' (based only on strictly relevant items and closely geared to the life situation and special nursing/therapeutic needs of that individual patient) may be constructed, employing behavioural criteria related internally to progress in each chosen item and presented in the form of a five-point semantic scale (Snider and Osgood, 1969) (Appendix 5). In aggregate, these scalar expansions form a generalised 'recovery index' for the items of the BAI, which will itself become the focus of therapeutic intervention.

4.3.6.6 Theoretical Basis of the RI Development

Hardyck and Petrinovich (1976) described four types of measurement

scale: nominal, ordinal, interval and ratio. The ordinal scale appeared most suitable for the purposes of this study. In other words changes in patients' conditions could be represented in numerical values reflecting the amount of change in each assigned item. The fundamental characteristic of an ordinal scale is that the differences between values on it are not necessarily equal.

One of the problems associated with scaling is the halo effect (Oppenheim, 1966). To counteract this, a specific frame of reference was included regarding each situational assessment. In addition behavioural statements were included to describe each level (grade) on the RI scale. Scaling is a common trend for assessment, especially in the psychiatric field. Scaling helps to produce a range of options for assessment, thereby minimising the raters' anxiety about using extreme categories or central tendency (Oppenheim, 1966). Shaheen and Ibrahim (1979), eminent psychiatrists in Cairo University, support the use of scaling as a method in the holistic quantitative/qualitative approach. Their work on the phenomenon of emotional blunting resulted in the development of a six-point scale 'quantum'. They agreed on the usefulness of the policy of grading for clinical evaluations in everyday practice as well as for scientific research.

In the current research, patients were interviewed by the researcher to identify areas of difficulty. Items scored "N" (No) were reassessed using the Recovery Index to identify performance levels or the degree of improvement during the course of treatment. In this sense the RI facilitated the screening of patients' problems and helped in finding a basis for therapeutic intervention. Other problems identified or observed by the researcher were also displayed on the BAI₁₀₀ and RI, with patients'

consent. The same procedure was repeated by psychiatric consultants and social workers for both groups, experimental and control. Discussions followed to minimise discrepancies in ratings. Usually it was possible to reach a joint decision about the scoring of items.

At that stage of the study no further validation of these instruments took place; it was considered that a separate process would have to be completed as a further study. These two instruments were also considered as specific instruments developed primarily for the purpose of data collection for this study.

4.3.6.7 The Limitations of The BAI₁₀₀ and its RI

As was mentioned before, the BAI₁₀₀ items and its Recovery Index were used for data collection during the Sheffield phase. Numerous problems were identified which hindered the proper use of the BAI₁₀₀ and RI.

These included:

1. BAI₁₀₀ items were too many to score in the initial interview session
2. Avoidance of 'on-the-spot' recording of information (ie in the presence of the patient) presented a great difficulty in remembering all the items and their exact answers
3. Interview sessions devoted to the assessment of patients using the BAI₁₀₀ scale were either artificial, focusing on the monitoring of the presence or absence of items, or genuine, ie allowing spontaneous conversation which in many circumstances was of little relevance to the items in the BAI
4. Although the BAI₁₀₀ scale was meant to be a comprehensive assessment instrument, it did, however, leave out two crucial aspects of patient difficulties, ie self-assertion and dealing with family

problems

5. Filling-in the BAI₁₀₀ item scale was a very time-consuming process
6. The items tended to be a mixture, monitoring both pathological symptoms and ordinary accepted behaviour which gave rise to some confusion
7. It had a subjective view of normality which is difficult to test in relation to different cultures, race, social class, current fashion trends and individual capacities, e.g., Items 13, 54, 64, 70, 85 (Appendix 4).
8. Many of the items were somewhat elementary and therefore unnecessary

To fulfil this need further extensive modifications were made to both the BAI and RI to produce a consistent, valid, reliable instrument. A plan was designed and implemented to improve the efficiency of the BAI and RI; this was the second stage of their development and will be called the validation phase.

4.3.6.8 The Validation Phase and the New Version of the BAI₃₀

The BAI₁₀₀ items were considered as a pool of items from which items of very low loading as shown by the data of both groups in Sheffield were omitted. Factor analysis of the 100 items showed that a number of items were redundant. In addition advice was given by a behavioural therapist and a consultant psychiatrist. The items were reduced to 65 and then the researcher added a further two items considered to be important because they covered areas previously not covered, that of assertion and family problems; thus there were then 67 items (Appendix 10).

At this stage the aim was to link the patients' level of adjustment with

the items, and to test their consistency. To identify this relationship, ten raters were asked to evaluate the 67 items. Questionnaire forms about the 67 item were given to them together with a manual for guidance on how to fill them in (Appendix 10). Only eight raters were able to respond within the time limit of two weeks. The raters involved in this evaluation process were: one consultant psychiatrist; one psychiatric senior lecturer; one behavioural therapist, one CPN, two social workers and two staff nurses working in the psychiatric unit. The questionnaire asked raters to choose items of most importance according to the following criteria: important; useful; relevant; assessment possible; no problems in scoring. All items scored Important were included, items scored positive on the other three factors together were also included. Items which failed to score Important or Useful were rejected. As a result the BAI₆₇ was shortened to 30 items. (Appendix 11). Further testing of the validity of these 30 items was conducted using the same raters and the same procedure. On this occasion only 5 raters were able to contribute. This validation procedure was designed and performed under the supervision of Mr A Cashdan, an experienced psychologist and internal supervisor to the programme.

The result of this stage was that the BAI₃₀ became combined with the Recovery Index to produce a five-point scale (a range from the most appropriate situation to the worst possible situation). Thus the newly developed instrument consisted of 30 items measured on a five-point recovery scale linked with a guidance manual which identified the situational assessment and criteria (Appendix 12). Further face validation of the BAI₃₀ items was also developed with the help of Mr A Cashdan.

Statistical validity asks ideally for 100% consistency; this was not possible

at the beginning of the validation process because of the following:

- a) raters would not agree without long training
- b) the abstract meanings of related concepts present difficulty when measured in numerical values
- c) extent of raters' knowledge of, and nature of relationship with, patients is varied

The following outcomes were obtained after the second validation procedure:

- a) All raters accepted the new form of the BAI₃₀ item scale and considered all the items both important and useful; one participant suggested an improvement in the criteria for Item 4.
- b) Other suggestions were made to improve Item 18.
- c) 100% consistency or agreement on all items was achieved by elimination of the scores of one atypical participant.

On this occasion the raters consisted of one psychiatric senior lecturer, one social worker, one CPN and two staff nurses. The final stage of validation was reached by carrying out their recommended modifications. The final shape of the modified BAI₃₀ instrument included situational assessment, and individual criteria linked to a five-point scale.

The BAI₃₀ consisted of three sections (Appendix 12):

Section A	Communication and social skills	9 items
Section B	Insight	9 items
Section C	Self and family care	12 items

Section D (Work and Recreative Activities) was rejected as only two of its items were considered important and useful; these two items were included in Section C.

Full behavioural validation would have been ideal but it was not possible at this stage. Some systematic assessment of the practical items was carried out when advisable.

The Reliability of the BAI

Along with the validation process, the inter-rater reliability was also tested on the BAI₆₇ item scale. This involved two procedures: the first was by means of presentation of a videotape. This tape was produced especially for the purposes of the research and it consisted of four semi-structured interview sessions with four different patients. Three interviews were carried out by the researcher whilst the fourth one was taken from a psychiatric education video. Two patients were chosen from the wards and a third one from outpatients. Patients were chosen by Professor Seager, a consultant psychiatrist who considered they presented their complaint/disability clearly, ie would feature on the BAI₆₇ items. The patients agreed to have videotaped interviews and each session took one hour. A master videotape of 40 minutes was made out of the four interviews. As previously mentioned, the BAI₆₇ items and manual had been distributed one week previously. Seven raters were able to view the videotape and make an assessment using the BAI₆₇; this was done in a single session lasting a couple of hours. The tape was presented at ten-minute intervals, ie showing the interview for ten minutes, then taking 10 - 15 minutes to make the assessment. The aim of this procedure was to reach 100% reliability but this proved impossible to achieve. This method in fact failed to achieve an acceptable degree of inter-rater reliability;

however it was helpful in eliminating the items which were subject to considerable disagreement.

A second method to measure inter-rater reliability using the BAI₃₀ was then tried. This consisted of four raters assessing four patients on four successive days according to the following schedule:

	P ₁	P ₂	P ₃	P ₄
D ₁	R ₁	R ₃	R ₂	R ₄
D ₂	R ₂	R ₄	R ₁	R ₃
D ₃	R ₄	R ₁	R ₃	R ₂
D ₄	R ₃	R ₂	R ₄	R ₁

P = Patient
R = Rater
D = Day

On average the inter-rater reliability reached acceptable levels ranging between 50-75%. Few items failed to achieve any degree of inter-rater reliability. However, these results suggested that further modifications would not be necessary but that perhaps more training was needed in the proper use of the instrument. No further testing of the instrument was done in Sheffield but one more test was carried out in Cairo.

Patients in Sheffield were then reassessed using the new version of the BAI₃₀.

4.3.6.9 Testing Validity and Interrater Reliability of the BAI₃₀ in Cairo

Face validation was conducted by the consultant psychiatrist Dr Ali El Bahtimy MBBCH DPM (London). Further validation was conducted by

both the consultant and researcher to measure the consistency of the BAI₃₀ items in relation to the health status of four patients with different diagnoses: i.e. depression, schizophrenia (paranoid), anxiety neurosis and personality disorder. Fortunately all items of the BAI appeared to be sensitive in measuring fluctuations in patients' health status. Items were highly consistent with most of the complaints.

In regard to the inter-rater reliability, four members of the medical staff were invited to assess four patients on four successive days. The method of using the BAI₃₀ and its scoring technique were explained in detail and clarification of ambiguous points was provided, e.g. one question raised was the assessment of the sexual behaviour of the patients as described by item number 18 (Appendix 11). The raters agreed to accept the cultural and religious rules regarding that matter, i.e. homosexuality and extra-marital sexual relationships were considered to be inappropriate during scoring.

In that sense the inter-rater reliability was tested by following the same procedure previously used in Sheffield. In other words the same four patients participating in the validation process in Cairo were assessed by the four junior psychiatrists on four successive days. The schedule for this test was identical to that used in Sheffield.

Surprisingly the results obtained in Cairo were more consistent and inter-rater reliability was higher, ranging on average between 75-100%. There was very little disagreement at 0% level and some at the 50% level. These results could be explained by the fact that the raters in Cairo were all doctors trained to make assessments and use similar procedures and forms; also the explanation of this particular procedure by the researcher

was more specific and drew their attention to the difficulties encountered by their counterparts in the Sheffield experiment. As the instrument had now developed and achieved a satisfactory level of inter-rater reliability it was deemed ready for use; further improvements could be carried out in a separate study if necessary.

4.4 Sampling Strategy

4.4.1 In Sheffield

The Target Population

Twenty-four patients were to be chosen for the sample but only twenty-two patients agreed to participate in this study in Sheffield. Both male and female subjects were involved. The 22 patients were presented as two groups: an experimental (Group A, N = 11) and a matched control (Group B, N = 11). Patients were selected according to the following criteria:

- a) Voluntary participation and agreement to cooperate with the researcher. The purpose of the study, its duration and expectations from participants were explained to them to allow them to base their decision on this knowledge.
- b) Age group of 20 - 60 years was considered to be broad enough to include the range of in-patient population of an acute psychiatric unit who would have a variety of complaints or disorders that would be appropriate for the purpose of the study.
- c) Diagnosis: presented a variety of psychiatric disorders which included both neurosis and mild psychosis.*

* Mild psychotic disorder means patients suffer psychotic disorder like hallucinations and delusions but who are able to communicate and comprehend a therapeutic conversation.

- d) **Chronicity:** chronic hospitalised conditions were excluded. Only patients newly admitted to acute psychiatric units who were in need of immediate intervention were considered, as also were patients with a positive history of previous admissions who had been out of hospital for a period of 2-3 months and for whom after-care had been discontinued.
- e) Educational and social background was broadly identified. Patients needed to be able to read and write in the English language and be capable of comprehending and answering the questionnaire, with help and guidance if necessary.
- f) Patients with special problems were excluded, ie drug addiction, alcoholism, obsessive-compulsive neurosis and geriatrics.

Sampling Procedure

Random sampling was not possible as mentioned earlier in the introductory section of this chapter. In addition the following proved to be definite constraints to practice:

1. The ward capacity was 25 beds: based on the above criteria many of these would be excluded from the sample
2. Out of the 25, only patients admitted up to one week before the assessment was to take place could be considered
3. Not every patient fitting the criteria agreed to participate: during the course of the study 32 patients fitting the criteria were requested to participate in the project, only 11 patients agreed to.
4. Some of the patients had a very strong regional accent which made it

difficult for the researcher to communicate with them, as her first language was not English. Therefore these patients were excluded.

5. The sample 'drop-out' factor was relatively high among the experimental group as three patients withdrew from the study for different reasons, eg moving out of Sheffield or refusal of psychiatric care generally.

The research design (quasi-experimental and action research in a clinical setting) plus the above factors, dictated the use of purposive sampling.

The procedure was as follows:

1. All the 25 patients present on the ward in Spring 1983 met the researcher who explained to them the purpose of the study; the therapeutic help that could be offered (bridging therapy); the process of selection and asked for their co-operation. The meeting was also attended by the ward sisters and a number of staff nurses.
2. Screening of the already hospitalised patients on the ward to decide who fitted the criteria. This was done by examination of the files.
3. Individual sessions with each patient to explain the work and ask for co-operation.
4. The patients who agreed to participate were given the GHQ and EPI questionnaire forms to answer. A brief explanation of the process of completion of the questionnaire was given and assistance was also provided where necessary, eg clarification of some questions, how much time to spend on answering them. Some patients also requested

that the questions be read to them because they were in such small print.

5. Individual sessions were carried out using the detailed assessment of the BAI₁₀₀ item scale (the old version)
6. Newcomers were also selected following the same procedure.
7. It proved quite difficult to choose patients for the control group initially because it appeared to be unfair and unethical not to offer the control group the same support during their crises. Patients needed help and attention regardless of whether they belonged to an experimental or a control group and it was not possible to keep away entirely from those assigned to the control group.
8. After the termination of therapeutic care for the experimental group, it became less difficult to select the control group on a matching basis. The difficulty of avoiding the provision of therapeutic support was resolved by avoiding all participation in ward therapeutic activities.

Analysis of the Matching Process

Firstly, the experimental group was selected from patients on the ward who fitted the criteria and who agreed to participate. The resultant group numbered three. Newly-admitted patients were then invited to participate if they fulfilled the criteria. However the process was rather slow, as a few patients withdrew from the project before the compilation of the therapeutic programme. In the first six months only five patients continued with the research.

Secondly, simultaneous selection of a matched control group was initially undertaken. During the course of the work it became clear that active participation in ward therapeutic activities and the day hospital programme made it difficult not to be involved with patients in the control group. Two patients from the control group requested to join the experimental group and this request was accepted. Therefore the decision was made to select the control group after the discharge of the experimental group from hospital. During the period of control group selection no participation in the ward activities was pursued by the researcher.

In that sense, all patients in the control group were selected subsequent to the experimental group, which meant the prolongation of the data collection phase. The procedure of selecting a matched control group was most difficult. However, essential similarities existed between the experimental and the control group and thus they were very comparable. The following table presents an analysis of the matching by sex, age and diagnosis.

The diagnostic classification in the following table follows the ICD.9 which is used by consultant psychiatrists in Sheffield.

Table 4.2: Matching Process in Sheffield Experimental and Control Groups

Experimental			Control		
Age	Sex	Diagnosis	Age	Sex	Diagnosis
22	F	Anorexia Nervosa	22	F	Anorexia Nervosa
21	M	Paranoid Schiz	20	M	Paranoid Schiz
47	M	Depression (reactive)	57	M	Depression(reactive)
28	F	Anxiety/Depression in obsessive personality	27	F	Anxiety/Depression
27	F	Anorexia Nervosa/ Depression	25	F	Bulimia Nervosa/ Depression
20	F	Anorexia Nervosa/ Bulimia	19	F	Anorexia Nervosa
31	M	Paranoid Schiz	37	M	Obsession,Catatonic Stupor
21	F	Anorexia Nervosa, Anxiety/Depression	24	F	Anorexia Nervosa
25	M	Personality Disorder	32	M	Depression,Personality Disorder
30	F	Paranoid Schiz	22	F	Paranoid Schiz
21	F	Anorexia Nervosa Personality disorder	23	F	Anorexia Nervosa Depression

4.4.2 In Cairo

The Target Population

It was originally intended to choose a similar number of patients to that of the Sheffield experiment, but because of shortage of time and the previously mentioned difficulties, only 18 patients constituted the target sample in the Cairo study. Again both male and female patients were included but not in equal numbers, there being 10 male and 8 female patients. Similar criteria of selection as in the Sheffield group were

followed.

Sampling Procedure

Usually very few patients with neurotic difficulties are admitted to a mental hospital in Cairo; the rate of daily admissions to private hospitals is also very much controlled by economic factors. Similar to Sheffield, patients already hospitalised with neurotic problems within one week of admission were screened and those who fitted the described criteria were advised by their consultant to participate in the project. Such advice gave great impetus to the project as patients encouraged to participate were able to develop confident relationships with the researcher in a relatively short time. Therefore nearly all the patients who were in the hospital and who fitted the criteria agreed to participate, the only problem being that these were not enough in number.

Following the same sampling procedure as in Sheffield, both experimental and control groups were matched. The following table presents an analysis of the matching process.

Table 4.3: Matching Process in Cairo Experimental and Control Groups

Experimental			Control		
Age	Sex	Diagnosis	Age	Sex	Diagnosis
56	M	Depressive Situational disorder	47	M	Situation Depression (endogenous depression?)
31	F	Acute Situational Depression	22	F	Manic/Depressive Symptoms
52	M	Acute Situational Depression	52	M	Anxiety/Depression (Personality Disorder?)
25	M	Anxiety/Depression Aggressive behaviour. Epileptic fits following brain surgery	25	M	Situation Depression + Personality Disorder
20	M	Depression, personality disorder?	23	M	Anxiety/Depression
28	F	Personality Disorder	25	F	Situational Depression + Personality Disorder
28	M	Depression	42	M	Depression, abrasive Personality
32	M	Depression	38	M	Depression
25	F	Manic/Depressive disorder (mania)	22	F	Manic Depressive, hysterical fits

As was mentioned earlier in Chapter 1, the Egyptian psychiatric classification follows the Diagnostic Manual of Psychiatric Disorders (DMP-1) which is based on the International Classification of Disease (ICD-8) with a code system allied to French classification, (Gawad, 1981). The DMP-1 was produced by the Egyptian Association of Psychological Medicine in 1975 (Shaheen and Ibrahim, 1979) and was the one used by psychiatrists in Cairo.

Contrary to the Sheffield experiment, in Cairo the experimental and

control groups were chosen simultaneously. This was because of the following:

1. There were few activities which necessitated an active part by the researcher or presence as a field observer. Intervention was mainly via individual therapy sessions.
2. In Cairo, immediate matching was pursued whenever possible.
3. The shortage of time available for the researcher to undertake data collection in Cairo necessitated this approach.

No specific social or educational background was specified as a criterion; the subjects did, however, represent a wide range of social and cultural backgrounds. Some patients expressed difficulty in understanding the questions; others complained about the small print; others were suspicious of the questionnaire method. Relevant explanations of the purpose and procedure for answering the questionnaire were provided and patients were provided with the Arabic version of the GHQ and EPQ questionnaires.

Problems of inter-rater reliability did not arise in the Cairo experiment, due to joint consensus assessment by the researcher and the consultant, carried out immediately after interviewing each patient, using the later modified version of the BAI₃₀ item scale.

4.5 Implementation of Bridging Therapy

4.5.1 In Sheffield

Bridging therapy aimed at producing a comprehensive model of care which

would provide an integrated service for patients. This was implemented in ten stages in the following sequence.

- 1 Introduction of the bridging therapy experiment to ward 56 staff in Northern General Hospital including nursing staff, day hospital staff, medical staff, social workers etc. Discussion focused on the details of the experiment and the type of help/co-operation that was required from them. A number of concerns regarding the nurses' role, role overlap and workload were expressed. Careful examination of each of the above is included in the discussion in Chapter 6.
- 2 A meeting was held with all the patients on the ward (capacity 25 beds) to introduce to them the bridging therapy research project, and ask for their co-operation. Questions asked by a number of patients, included the length of the study, which consultant was in support of the project and the nature of confidentiality of patients' problems. Patients were reassured that all of the consultants on the ward were supportive of the project and that all information obtained would be kept anonymous. Nevertheless none of the patients agreed to take part at this stage.
- 3 Individual patient interviews were conducted to eliminate misunderstanding and encourage their participation. After a number of attempts only three patients out of 25 agreed to be included in the experimental group. It is important to mention here that all patients on the ward at that time fitted the research sampling criteria specified. This procedure was followed regarding newly-admitted patients, i.e. every newly-admitted patient (who fitted the criteria) was interviewed on an individual basis. Patients who refused to

participate in the experimental group and had psychiatric disorders similar to those in the experimental group were initially encouraged to join the control group. Nevertheless, simultaneous selection did not prove feasible as discussed earlier in the sampling strategy.

- 4 Assessment of patients in the experimental group was conducted on admission using the Eysenck Personality Inventory, (EPI), General Health Questionnaire (GHQ₆₀) and the Behavioural Adjustment Inventory (BAI), to assess patients' adjusting behaviour both in hospital and community. Details of its development, validation and inter-rater reliability have already been discussed. The EPI and the GHQ were completed by the patients as they are self-report questionnaires; while the BAI was completed by both the researcher and the consultant psychiatrist. The use of the GHQ as a self-report questionnaire had the benefit of counteracting possible biases appearing in the scores of the BAI.
- 5 Care plans were devised based on a specific model of the nursing process. According to this model of nursing process, patients' immediate problems, needs, and requirements were identified. Short- and long-term therapeutic objectives were identified. The context of the problem was examined in relation to the patients' social background and pre-morbid personality.

Plans of intervention regarding each patient from a holistic point of view were produced. Each plan of care was comprehensive enough to employ the hospital resources, community resources and the service of other disciplines as appropriate. Involvement of the patients and their families in decision-making was a current practice. No

limitations were set on the location of care delivery, i.e. inside or outside the hospital walls; e.g. a patient who needed to do some shopping was allowed to drive in her car to the city centre, joined by the researcher. This was most helpful for the patient to regain self-confidence and resume her independence. Planning for community follow-up was also included at this initial phase.

- 6 Bridging therapy intervention employed the Flexible Integrative Approach (FIA) as described in Chapter 3. As mentioned earlier, the FIA is based on the eclectic position, including reality therapy and supportive psychotherapy. Therefore each patient was able to receive a therapeutic approach that employed and combined techniques from different schools of therapy, e.g. family therapy or marital therapy was used with an individual psychodynamic approach or rational-emotive approach. (Further details of its implementation are included in the case studies).
- 7 Evaluation of the care plan was carried out in relation to patient outcomes and the preplanned objectives (short/long term). Evaluation was an integral part of the implementation of bridging therapy, as was sensitivity to the changing shape of patients' needs and/or progress. As mentioned earlier, a holistic approach to patient care was employed; therefore assessment of relevant areas of dysfunction other than psychiatric disorders were also monitored, e.g., patients who needed to change, or obtain accommodation, or develop certain technical skills. Evaluation was guided by the BAI assessment format. The BAI₁₀₀, RI and GHQ forms were completed for the second time on patients in the experimental group on discharge from hospital. Again, the researcher and consultant completed the

BAI₁₀₀ and the RI, while the GHQ was completed by the patients.

- 8 Detailed plans for community follow-up care were designed with the patient, his/her family and members of the appropriate disciplines, e.g psychiatrist and/or social worker. At this stage assessment of adjusting behaviour outside the hospital, identification of possible emerging problems and the different resources required whether in the hospital or in the community was undertaken.

In this context, community services are not solely confined to those available from health services, but encompass all services and facilities available to any citizen: e.g. Public Library, housing and financial advice; churches or any other religious communities; and places for entertainment. A major problem is that patients with inadequate social skills and living on their own find it very difficult to pressurise for such resources independently. Therefore on many occasions, patients in the experimental group were encouraged to meet with the researcher in one of these public places during the community follow-up phase.

- 9 Community follow-up was carried out for a period of 3-6 months in order to ensure adequate support necessary for patients' resettlement in society. The therapeutic intervention strategy which commenced during hospitalisation was continued in the community. This strategy was fruitful in eliminating some of the discrepancies between caring practices of different disciplines which often occur. On a few occasions joint home visits for patients were conducted and on other occasions a psychologist joined family therapy sessions in the community.

Community follow-up was not restricted to working hours 9 -5.30 pm or weekdays only. The first few patients who were discharged from hospital while the rest of the experimental group was still hospitalised, had to receive follow-up visits either in the evening or during the weekend. These arrangements were made at the patients' convenience.

- 10 Termination of the follow-up was not only controlled by the defined period (3-6 months) but also by individual patients' needs. Some patients' follow-up care was within the three months while others needed more than six months. Decisions regarding the timing for termination of the researcher's follow-up were made jointly with consultants who arranged other forms of follow-up as necessary. One patient from the experimental group who suffered from paranoid schizophrenia has received continuous support for a further year through his social worker. That social worker was his social worker in the hospital, so the principles of continuity of care were sustained.

4.5.1.1 Bridging Therapy Compared with Current Conventional Provision

Conventional provision was shown by the research as a fragmented service lacking in co-ordination, systematic assessment and comprehensive programmes of care. Detailed analysis of this statement follows.

1 Fragmented Service:

This problem presented itself on two levels. Firstly, there was lack of communication between CPNs, GPs and the hospital staff. Only rarely was a CPN or a GP invited to one of the regular weekly ward rounds. Brief written reports were the standard practice. Secondly, fragmentation occurred within the hospital itself among staff from

different disciplines. Very frequently one would see a psychologist, behaviour therapist or social worker producing a list of required activities to be carried out by the nurses for the patient without there being a joint session to discuss the process of its integration. The end result was usually a task-oriented plan directed towards specific problems or psychiatric disorders. Many such inconsistencies were witnessed during the nurses' implementation of these specific activities. Therefore they were successful in dealing only with the patients' immediate needs.

2 Lack of Co-ordination:

This became most critical after a patient's discharge from hospital. Such patients may continue to see their art therapist and their social worker, or become day patients. When this occurred, patients were liable to receive unnecessarily duplicated or conflicting messages, since there were no multidisciplinary discussions or ward rounds at which the progress or predicaments of ex-patients could be discussed in relation to their after-care.

3 Lack of Comprehensive Programmes:

Generally speaking, the term "comprehensive care" is not clearly defined in the literature or by health authorities. Sometimes it refers to the combination of different services, e.g. occupational therapy, group therapy, recreational therapy - in one place. Whilst such provisions represent some important components of comprehensive care, they do not represent its totality.

It appears that the conventional model is more concerned with patients' psychopathology than with the holistic outlook. It also

encourages both patients and their families to be more dependent on the state facilities provided rather than developing a progressive long term family support system that would help the families to look after their ill members.

4 Lack of Systematic Assessment:

Following from the previous point, assessment in the conventional model is very much problem-oriented. It focuses on patient's history and would emphasise either the organic, social or psychological aspects of patients' difficulties, in accordance with the consultant psychiatrist's particular interests. Both in hospital and community, nurses used different forms for patients' profiles and they did not question how relevant the items or questions on these forms were to what is really observed in the patients' assessment.

4.5.2 Implementation of Bridging Therapy in Cairo

In Cairo bridging therapy offered a new dimension in the psychiatric nursing care of mentally ill patients, in the form of community liaison and home visits. In Cairo the concept of bridging therapy was regarded by psychiatrists in El-Niel sanatorium as a very new idea in community care, which is currently limited to out-patient clinics and psychiatric follow-up.

Because of these factors, the researcher anticipated possible doubt and disapproval on the part of the hospital-based staff at El-Niel Sanatorium in Cairo. Contrary to these expectations, the director and consultant psychiatrist at El-Niel Sanatorium acknowledged the potential importance of bridging therapy and gave welcoming approval for the study to take place in his hospital and with his patients. He also promised complete co-operation and guidance as required.

On arrival at El-Niel Hospital, the following steps constituted the implementation process for bridging therapy:

- (1) Explanation and co-ordination of work with the medical and nursing staff. A staff meeting was held at which the researcher was introduced to the staff. At that meeting the concept of bridging therapy was introduced and discussed. Special interest was expressed by members of the medical staff in the experience gained by the researcher through working in Sheffield; and the range of facilities available to the British people in comparison with the limited resources for Egyptian patients. They also appreciated the importance of liaison between hospital and community, and regarded bridging therapy as a potentially useful option for care. Members of the nursing staff promised co-operation and provision of feedback concerning patients' behaviour on the ward.
- (2) Another meeting was held with the consultant, the medical staff and the researcher, to discuss in detail the recording techniques for the BAI₃₀. No Arabic translation was required for the BAI₃₀ since all medical staff involved in assessment spoke fluent English.

Initial testing of the validity of the BAI₃₀ with the demonstrated difficulties of four patients in the hospital was conducted both by the researcher and by the consultant psychiatrist. All 30 items appeared to be sensitive measures of the patients' adjusting behaviour.

Inter-rater reliability was also tested in the Egyptian context. On this occasion four members of the medical staff were asked to assess four patients on four successive days (a similar procedure to that

used in the Sheffield phase of the study, as discussed earlier in this chapter.)

- (3) A review of the patients' files helped the researcher to identify patients who conformed to sampling criteria. These patients were interviewed in the presence of the director of the hospital who encouraged their participation. During these initial interviews, patients received clear and simple explanations of the bridging therapy programme; the community follow-up and home visits; and the questionnaire forms. Patients welcomed participation in the proposed research and seemed to regard the home visits and follow-up as a social event (see 5 below).
- (4) Patients were requested to fill in the two questionnaires (GHQ and EPQ) in their Arabic versions. A detailed account of the problems encountered during this phase is included in the section entitled "Data Collection Instruments". Assessment of the patients' conditions using the BAI₃₀ was carried out in joint session between the consultant and the researcher for the experimental group: whilst assessment for the control group was carried out in joint session between the consultant and the patients' medical keyworker (i.e., junior psychiatrist).

As with the Sheffield phase, assessment took place within the first week of a patient's admission. Individual interviews with patients were helpful in gaining their confidence and acceptance. Initial interviews carried out jointly with the consultant psychiatrist ensured rapport and saved much time in getting to know the patients. A further consideration was the ethnic similarities between the researcher and patients in the Egyptian context and conversely the ethnic differences

in the British context. An example of the dissimilarities in the British context is the female patient who expressed her dislike of the researcher openly, apparently on a racial basis, during the orientation phase in Sheffield.

- (5) As was mentioned earlier, El-Niel hospital does not provide a wide range of activities for patients. Therefore no active participation in the patients' daily activities was required. Consequently both experimental and control groups were chosen simultaneously (see Sampling Strategy). The experimental group received a planned programme of care based on identical principles to those of the Sheffield sample. Individual psychotherapeutic sessions, family therapy or marital therapy constituted the main interventions there. The remaining stages of implementation of bridging therapy in Cairo were identical with the Sheffield phase. However, the process of home visiting for Egyptian patients was somewhat different from the Sheffield context.

Patients with limited education perceived the home visits as social events; this resulted in some time being spent in social 'chat' not directly related to the therapeutic process.

Interestingly, some patients in the experimental group and their families were anxious to obtain advice regarding physical health, dietary problems and physical exercise. This observation may reflect Egyptian society's emphasis on physical aspects of an illness rather than on psychological aspects. Similar observations have been made by Okasha, Kamel and Hassan (1968).

4.6 Methodological Limitations

The following limitations of the method described need to be considered:

- (a) the sample size was relatively small, restricting attempts at generalisation of results.
- (b) the purposeful sampling approach used could lead to bias in conclusions.
However, the researcher does not regard the sample as too strongly biased, as there is some inherent randomisation in that every newly admitted patient who fitted the selection criteria and agreed to participate was included.
- (c) the heavy involvement of the researcher in the daily therapeutic activities in the ward in the Sheffield context could have had a clouding effect. This could possibly lead to diminished objectivity of the observations. However, the use of the GHQ questionnaire to cross-validate the researcher's observations with those of the patients and the consultant psychiatrists, safeguarded this to some extent.
- (d) the possibility of halo effects was high in this design. However, the use of a matched control group helped reduce this effect. Other strategies employed included a six-month familiarisation and orientation period when the researcher became a member of the therapeutic team in order to minimise halo effects.
- (e) many studies in the field of psychiatry have demonstrated the problems associated with the measurement of patient outcomes as criteria for the effectiveness of a therapeutic programme.
Nevertheless, the researcher could not find a more suitable alternative. Usually patients' progress is influenced by many independent variables other than therapeutic programmes.
- (f) as there were very few evaluative studies in the field of community

mental health nursing that have produced patient assessment instruments in hospital and community contexts, it was necessary to devise one. In retrospect, it may have been more desirable to focus on developing either the BAI or bridging therapy.

- (g) the development of the BAI₃₀ as a valid, reliable instrument was very time-consuming and was only conducted on a small scale, ie only to serve the purpose of the study. Full behavioural validation will be needed to improve its efficiency.
- (h) matching between experimental and control was according to age, sex and diagnosis. However, there are no two people exactly alike and this presented selection difficulties which are frequently inevitable in behavioural studies.
- (i) patients' attitudes could sometimes diminish the success rate of the experiment. This was particularly true of patients in Sheffield who refused to participate, possibly to avoid the stigma of a follow-up in their home, after hospitalisation in a psychiatric unit. This was a surprising observation, as it was at first assumed that Western society had developed an understanding view of mental illness. On the other hand, the patients in Cairo welcomed the follow-up and home visits, which again was very surprising considering that society stigmatised mental illness. However, during the course of home visits it became clear that some patients regarded the visits either as social, i.e. to show their hospitality to the researcher, or as purely medical follow-up where they can enquire about their physical health problems and ask for advice.
- (j) there was a contamination factor in the Sheffield context - in that the control group received follow-up from their social workers, or by attending the Day Hospital. These artefacts were not considered at the beginning of the study. In Cairo the researcher expected to

encounter a less contaminated environment for the study, but here the important family support factor was not allowed for.

- (k) the researcher came from a different cultural background and therefore worked to some extent from a different conceptual framework. Some patients in the Sheffield context found it difficult to accept her, for two possible reasons. Firstly they were reluctant to be 'guinea pigs' (an overt expression); and secondly they felt unable to trust a 'foreigner' (again overtly expressed to a member of staff). Trust was much easier to obtain in the Egyptian setting. However patients in the experimental group were somewhat puzzled by the novel role of nurse therapists and a nursing follow-up service. This could be due to the traditional concept of lay people in Egypt, that the nurse's role is confined to giving medications and injections.
- (i) the choice of semi-participant observation and in-depth interviewing as qualitative methods of data collection served the objective of phenomenological inquiry well. However, they proved very time-consuming, requiring a great number of hours over three years of total involvement in the clinical and practical aspects of the study.

It might have been more helpful for the researcher (as an 'outsider') to have utilised less time-consuming methods of data-collection such as non-participant observation and second-hand 'reliable' reports.

4.7 Summary

The conceptual basis for selecting and developing the research design is discussed. The framework stresses the importance and relevance of

employing both quantitative and qualitative approaches in the current study. Quasi-experimentation and action research approaches are therefore employed. Compromise strategies to compensate for the weaknesses of each research style if used separately are discussed in detail. Later discussion focuses on the actual implementation of these methods, with special reference to the limitations of the methods used.

CHAPTER 5: RESEARCH FINDINGS

5.1 Introduction

5.2 Description of the Samples

5.2.1 The Sheffield Sample

5.2.2 The Cairo Sample

5.3 The Quantitative Findings

5.4 The Qualitative Findings

5.4.1 Detailed Case Study No. 1 (Sheffield Field Work)

5.4.2 Detailed Case Study No. 2 (Sheffield Field Work)

5.4.3 Detailed Case Study No. 3 (Cairo Field Work)

5.4.4 Detailed Case Study No. 4 (Cairo Field Work)

CHAPTER 5: RESEARCH FINDINGS

5.1 Introduction

Data obtained in this study were subjected to two types of analysis: quantitative and qualitative. This was due to the nature of the work involved in studying human behaviour. The findings are presented in three parts; first, the overall picture of the subjects who participated in the study; second, the statistical analysis of the quantitative data; and third, a descriptive analysis presented in the form of case studies as a tool for qualitative methods. Comparisons between the outcomes of the Sheffield and Cairo samples are included where relevant.

5.2 Description of the Samples

Patients who participated in this study were both male and female with no attempt at using equal numbers. Matching between experimental and control groups was based upon similarities in sex, age and nature of problem.

Table 5.1: Sex distribution both in Sheffield and Cairo samples

	SHEFFIELD		CAIRO	
	Experiment	Control	Experiment	Control
Male	4	4	6	6
Female	7	7	3	3

The age range was between 20-56 in the Sheffield groups with a mean of 38 years. The Cairo group ranged from 20-57 with a mean of 38.5 years.

5.2.1 The Sheffield Sample

In the experimental group in Sheffield, two male patients and one female

patient were married. All the single female patients were living on their own during the treatment, apart from one who was living with her mother. The single male patients were living with their families at the beginning of the treatment but later moved to partly supervised hostel accommodation (the halfway house). In the control group one male patient was married but none of the female patients were married.

Two single female patients in the control group were living with their families before hospitalisation but after discharge one moved to live on her own. Of the single male patients two were living with their families and one was living on his own but then moved to a supervised hostel after discharge from hospital (The Dry House, for alcohol abusers).

Table 5.2: British sample distribution - living with family or on own

	Experimental				Control			
	Living with family		Out of family		Living with family		Out of family	
	Before admission	After discharge	Before admission	After discharge	Before admission	After discharge	Before admission	After discharge
Male	4	3	-	1	3	3	1	1
Female	2	1	5	6	2	1	5	6

During the period of follow-up of the experimental group, one male patient was re-hospitalised for a short period (2 weeks) and another went to prison. One female patient was re-hospitalised for two months and another committed suicide after the termination of the follow-up.

In the control group two male patients were re-hospitalised during the post-discharge period. One male patient died of alcohol poisoning afterwards. Four female patients were re-hospitalised for varying periods

ranging from two to twelve weeks.

With regard to previous admissions, two male and three female patients had previous hospital histories. Similarly in the control group, there were two male and three female patients with a history of a previous admission.

Table 5.3: British sample outcomes in relation to hospitalisation or death

	Type	Previous admission	Rehospitalisation /Prison	Death +
Male	Experiment	2 patients	2	
Female	Experiment	3 patients	1	1
Male	Control	2 patients	2	
Female	Control	3 patients	4	1
+ occurred later, after termination of follow-up				

Termination of the follow-up of the post discharge period and the assessment took place within six months after hospital discharge. The cases resulting in death, one from the experimental group was a suicide and one from the control group was from alcohol poisoning. All patients in the sample were hospitalised within one week prior to the first assessment.

All the patients, both experimental and control groups, received therapeutic and rehabilitative programmes as part of the hospital routine. These programmes ranged from intensive individual or group therapy, behaviour therapy and different social activities to simple manual skills and craft workshops. Every patient had key workers: nurse(s), social worker, and psychiatrist(s). After discharge, patients who needed the continuity of hospital care continued to attend the day hospital rehabilitative programmes. The same social worker and psychiatrist(s) key workers

continued with the follow-up programme, but not the nurse(s). In addition the experimental group received individual therapeutic sessions and follow-up from the researcher.

In the experimental group two of the male patients were helped to join the 'halfway house' for the purpose of improving their independence and avoiding family troubles. One female patient was helped to get a room in a shared council flat; another female patient was helped to get her own council flat. In the control group one male patient was helped to get a place in the Dry House (supervised hostel for patients with alcohol abuse); and another was helped to get sheltered work with some charity bodies. Two female patients from the control group were helped to get council flats and another was helped to join a training scheme.

5.2.2 The Cairo sample

In the Egyptian context none of the patients, either male or female, were living on their own. The family style of life was the main feature; either nuclear family for married patients or extended family for single patients.

Table 5.4: Married/single distribution in the Egyptian sample

	Experiment	Control
Male	Married 2	Married 4
Female	Married 2	Married -
Male	Single 4	Single 2
Female	Single 1	Single 3

All hospitalised patients received hospital care dominated by the custodial model. Activities during the hospitalisation period were limited to two types of manual and craft skills, outings, amusement games, watching TV and videos plus two types of therapy, group therapy and art therapy.

Visiting hours were all day between 10.30 am and 5.30 pm with one hour break at lunchtime.

After discharge medical follow-up was the only available service with one month between visits. The experimental group in the Egyptian sample received follow-up in the community from the researcher.

The family support and some occupational laws* were the main support that could be used in the community. There were no social workers attached to El-Niel hospital (a private hospital); however in all public and university hospitals there is a social work service attached to each department.

The medical director of El-Niel Hospital was the person who could help the patients to make use of the occupational laws; it was from his report that entitlement (or not) to the benefits of the law was assessed.

In the community the family were the source of social and emotional support but they were also the source of trouble and difficulties for patients.

As with the Sheffield group, patients in the Cairo experimental group were in regular contact with the researcher on either a daily basis or twice a week during hospitalisation, and on a weekly basis or twice a month in the community follow-up period. The community follow-up period in Cairo was only three months.

* According to Law no 112, which organises the occupational relationship and rights, nobody can be dismissed from work because of illness. Patients are allowed to continue at work doing less intensive or less complicated work with full payment.

None of the patients in the Cairo experiment were helped in terms of housing or a rehabilitative training programme because of the absence of such facilities. One patient in the control group was helped by his family to get his job back (he had resigned following a disagreement with his boss.

All patients in the experimental group were helped to deal with their family problems through direct contact with the family, orientation education and support for the family as well as for the patient. During follow-up the relapse rate was higher amongst controls than in the experimental group. Thus three "controls" were re-hospitalised whilst by contrast only one member of the experimental group was re-hospitalised for a short period of two weeks.

5.3 The Quantitative Findings

The data obtained comprised of two sets results each including three variables. Thus the data consisted of:

- a) data related to the British sample (Sheffield)
- b) data related to the Egyptian sample (Cairo).

Each group consisted of two groups, an experimental and a control group, who were subjected to an assessment on three occasions, admission, discharge and post discharge (end of follow-up). Two types of assessment instrument were employed in this study, the General Health Questionnaire (GHQ) and a specially designed inventory, the Behavioural Adjustment Inventory (BAI). The data were submitted to a two-way analysis of variance (groups by intervals). The first factor was between subjects and the second was within subjects.

The following table presents the analysis of the GHQ measurements of the

Sheffield group. One main effect interval ($F = 29.270$, $df = 2 \text{ \& } 40$ $P < 0.001$) proved reliable. A full mean table and a source table are given in Appendix 15.

The observed differences were further examined using Scheffé's t-test for multiple comparison (Edwards 1972). Table 5 shows the calculated Scheffé's test value at each interval.

Table 5.5: GHQ measure of improvement of the Sheffield sample at two intervals

Experimental and control:	Mean:	Interval:	t-test score
Admission (Ad)	37.22	Ad/D	$t = 7.35^{**}$
Discharge (D)	12.00	Ad/PD	$t = 5.29^{**}$
Post Discharge (PD)	19.27	D/PD	$t = 2.05$

*t crit (0.05) = 2.58 **t crit (0.01) = 3.23

The low scores in the GHQ measurement indicate healthier and better patient conditions. Table 5.5 shows significant improvement in both experimental and control groups. The greatest recorded improvement was in the difference occurring between admission and discharge; similar improvement was found between admission and post-discharge. Differences between discharge and post-discharge were not significant. Slight regression in the tendency for improvement was recorded; it was not statistically confirmed. The difference in improvement between the experimental and control groups was insignificant; therefore further analysis of differences between the experimental and control groups was not possible. Nevertheless any improvement achieved was higher amongst the experimental group, as seen in the source table of means, Appendix 15.

One explanation for this result could be that patients in the experimental group had presented higher levels of disorder on admission than that scored by the control group. This relationship appears in the differences of means on admission, as shown in the source table, Appendix 15. Another explanation could be the possible further increasing insight gained by the experimental group which might have led to an increase in problems reported and/or disorders.

Table 5.6 examines the overall tendency for improvement for both experimental and control groups jointly in Sheffield. The BAI₃₀ score analysis showed one main effect interval ($F = 49.022$, $df\ 2 \ \& \ 40$, $P < 0.001$) and one interaction group by interval ($F = 3.967$, $df = 2 \ \& \ 40$, $P < 0.05$) proved reliable. A full mean table and source table is given in Appendix 16. Results were highly significant at the interval Ad/PD at $p < 0.01$ and at Ad/D at $p < 0.001$. Further analysis for these obtained significant differences was done using Scheffe's t-test.

Table 5.6 examines in detail this interaction and presents the calculated values of each Scheffe's t-test on each interval. This result indicates that the sample not only maintained their achieved levels of improvement but also were able to achieve even more improvement after discharge.

Table 5.6: BAI₃₀ measures of improvement for the Sheffield sample on three occasions

Experimental and control	Mean	Interval	t-test score
Admission (Ad)	92.591	Ad/D	$t = 7.14^{**}$
Discharge (D)	118.182	Ad/PD	$t = 9.43^{***}$
Post Discharge (PD)	125.682	D/PD	$t = 2.29$

*t crit (0.05) = 2.58, **t crit (0.01) = 3.23 and

***t crit (0.001) = over 3.23

Further analysis of each group separately, ie experimental vs control, was conducted as shown in Table 5.7. This analysis showed no significant difference between the two groups. However it should be mentioned that the difference between the experimental and the control groups was very close to significance (t Scheffe's (0.05) = 3.03 and t critical = 3.20, df 2 & 40). Therefore this difference should be reviewed with the extreme conservatism of Scheffe's test firmly in mind.

As such the results indicate that the significant improvement occurring in both groups was mainly during the period of hospitalisation and was maintained at an average level after hospital discharge, yet the behaviour of the two groups was not similar in the second interval; the linear trend was very much higher in the experimental group than in the control, ie the experimental group tendency for improvement was higher than that of the control group. This relationship is shown in table 5.7, the source table in Appendix 16 and in Fig No 5.1.

Table 5.7: Comparison of improvement gained by both experimental and control groups of the British sample, as measured by the BAI_{30}

Variables	Exp.	Control	Interval	Exp.	Control
	Mean	Mean		t-test	t-test
A	90.36	94.82	Ad/D	$t=5.86^{**}$	$t=4.48^{**}$
D	119.36	117.00	Ad/PD	$t=8.65^{***}$	$t=4.71^{**}$
PD	133.18	115.18	D/PD	$t=2.29$	$t=0.24$

* t crit (0.05) = 2.58, ** t crit (0.01) = 3.22 and

*** t crit (0.001) = over 3.22

Therefore it is shown that the improvement tendency in the experimental group was higher than for the control group. The following figure clarifies this tendency.

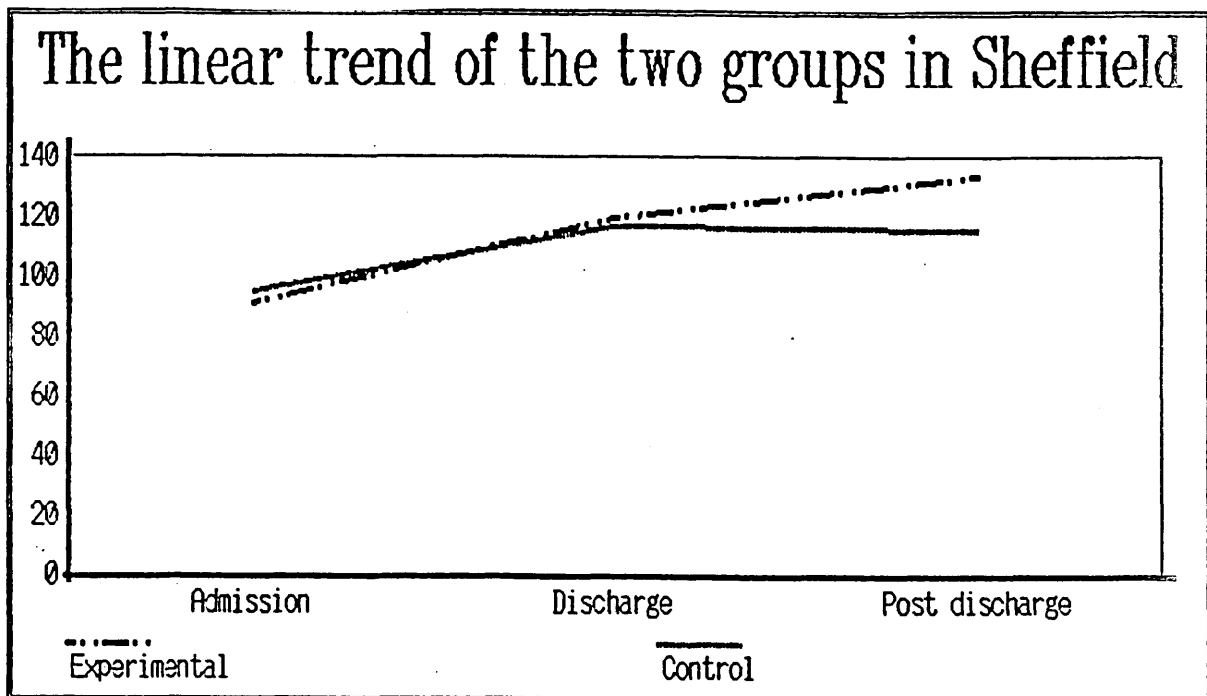


Figure 5.1: The linear trend of the two groups in Sheffield

The graphic presentation shows the consistent improvement pattern in general. It also shows the greater improvement tendency of the experimental group.

On admission the personalities of both groups were screened using the EPI for extraversion, neuroticism (plus lie/social acceptability scale). Statistical analysis showed no significant differences between the experimental and control groups. These results indicate that the sample was homogeneous and suitable for matching. A source table is provided in Appendix 17.

Quite interestingly, a consistent relationship was found regarding the GHQ scores obtained and those of the BAI₃₀. No statistical difference was found between how patients perceive their condition and how the raters (ie consultant and researcher) have evaluated the adaptive/maladaptive behaviour. This was particularly true of the second interval, ie Ad/PD. Such results would suggest the comparability of these two instruments in validating specific data.

With regard to the Cairo sample, there were nine pairs. A standardised translated Arabic version of the GHQ was used. The behaviour of the Cairo sample was almost identical to that of the Sheffield sample, as shown in Table 5.8, and the source table in Appendix 18. Analysis of variance of the second factor proved there were significant differences in the first and second intervals for both groups.

Table 5.8: GHQ measurement of improvement in the Egyptian sample on three occasions

Experimental and control	Mean	Interval	t-test score
Admission (Ad)	19.00	Ad/D	t = 6.11**
Discharge (D)	8.44	Ad/PD	t = 7.22**
Post discharge (PD)	6.28	D/PD	t = 1.11

p 0.05 = 3.09 and p 0.01 = 3.90

Similar to the Sheffield sample's behaviour on this test, significant improvement was recorded by the Cairo sample in respect of the two intervals Ad/D and Ad/PD at p = 0.001. No statistical difference was obtained for the third interval D/PD. Further analysis of the differences between experimental and control showed no statistical significance (a

source table is provided in Appendix 18).

The behaviour of the Egyptian sample was slightly different from that of the British sample with regard to the third interval. Using the GHQ, patients in the British sample rated themselves as being less improved in the third interval, whilst the Egyptian patients rated themselves as continuing to improve. One explanation could be the higher level of awareness gained by the British sample through their involvement in different forms of group therapy aimed at developing their insight and abilities to identify their difficulties more easily. The Egyptian groups did not have these facilities.

Improvement as rated by the BAI₃₀ for the Egyptian subjects was highly significant for both groups. In comparison with the GHQ, the Egyptian subjects tended to improve during and after hospitalisation, as shown in Table 5.9. Analysis of variance showed one main effect interval ($F = 19.457$, $df = 2 \text{ \& } 32$, $P \leq 0.001$) proved reliable. The observed difference was subjected to further analysis using Scheffé's t-test as shown in Table 5.9. A full mean table and the source table are in Appendix 19.

Table 5.9: BAI₃₀ measurement of improvement for the Egyptian sample on three occasions

Experimental and control	Mean	Interval	t-test score
Admission (Ad)	105.444	Ad/D	$t = 4.5^{**}$
Discharge (D)	122.778	Ad/PD	$t = 6.25^{**}$
Post Discharge (PD)	129.667	D/AD	$t = 1.5$

*t crit (0.05) = 3.9 and **t crit (0.01) = 3.90.

Table 5.9 shows that the significant improvement achieved by both groups

between admission and discharge and admission and post discharge, was similar to the British sample (results in Table 5.5). The differences between discharge and post-discharge were not statistically significant, but the tendency for improvement was maintained.

The analysis of variance of the first factor (ie between subjects) did not show any significant differences between the experimental and control groups on any of the intervals. Therefore no further analysis of variance was required. A source table is provided in Appendix 19.

The following figure illustrates this relationship.

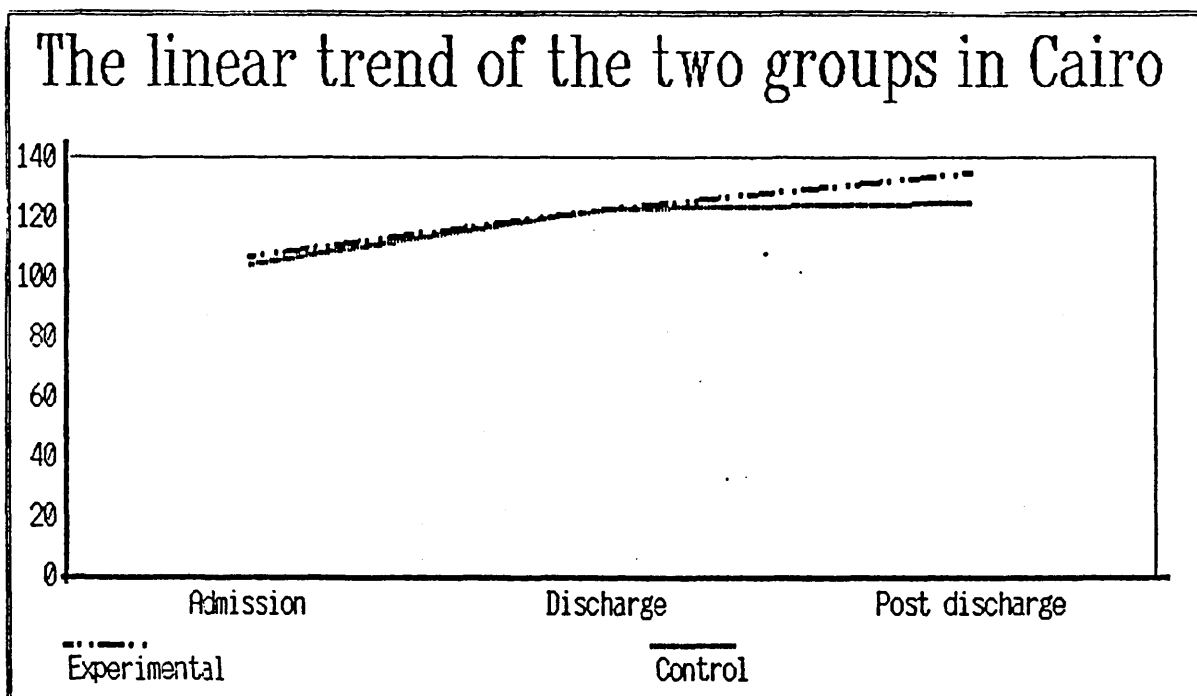


Figure 5.2: The linear trend of the two groups in Cairo

The screening of the personality of patients, their tendency for extraversion, neuroticism plus lie/social acceptability scale was tested by the completion of the EPQ (Appendix 4) (an equivalent version of the EPI, Abed El-Khalek,

1983) on admission to hospital . Statistical analysis revealed no significant differences between the experimental and control groups in the Egyptian sample regarding the three variables, extraversion, neuroticism and lie scales; ie a homogeneous matched sample (a source table is provided in Appendix 20). These results again are paralleled by their British equivalent.

To summarise these results: one can say that both groups in Sheffield and Cairo have behaved almost identically. The following figure (fig 5.3) shows a comparative relationship between both samples collectively with regard to the GHQ results.

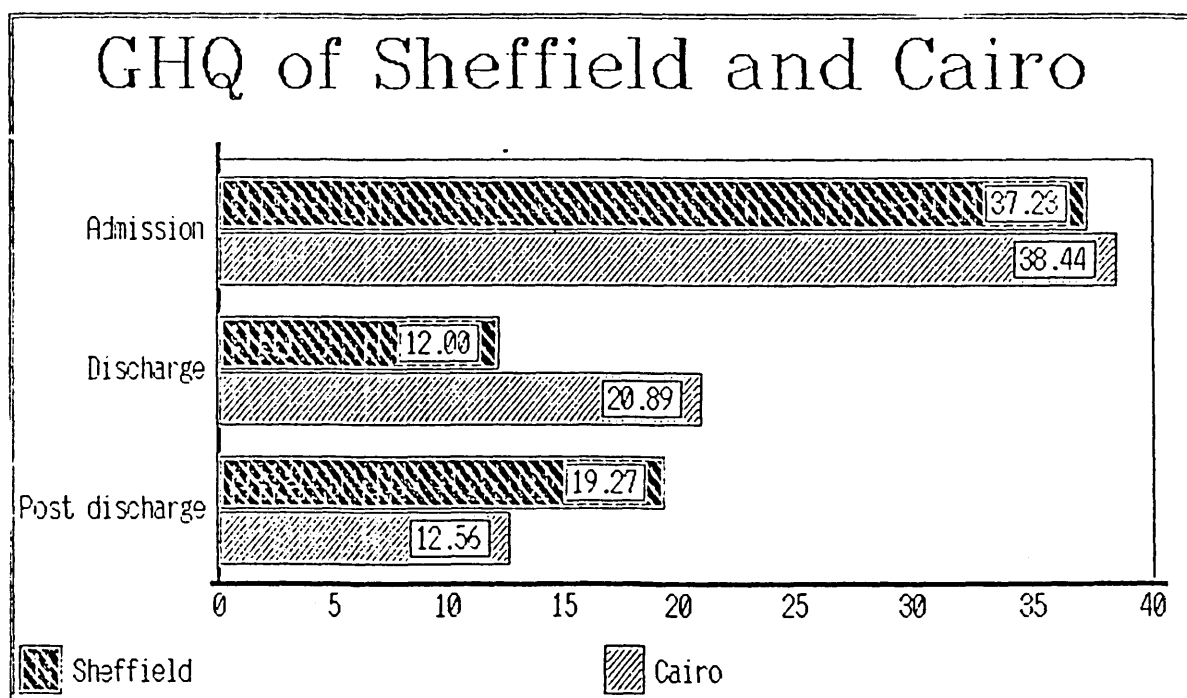


Figure 5.3: GHQ of both groups in Sheffield and Cairo⁺

⁺ For graphic presentation purposes, the scores of the Cairo sample on the GHQ were doubled as the Arabic version of the GHQ had only 30 questions

Patients in both samples scored significantly high on GHQ admission scores, which indicated the patients' perceptions of experiencing illness were high. A significant decline in the scores were recorded on discharge from hospital for both groups. The Sheffield sample post-discharge scores showed a slight increase in the experience of illness once again; however this score was not statistically significant.

An identical consistent relationship was found in relation to the BAI_{30} scores of the two samples, as shown in Figure 5.4. In this figure the higher the score, the better the adjustment. Apart from the slightly lower score obtained by the Sheffield group on admission, both groups were almost identical on the level of improvement achieved on discharge and post-discharge.

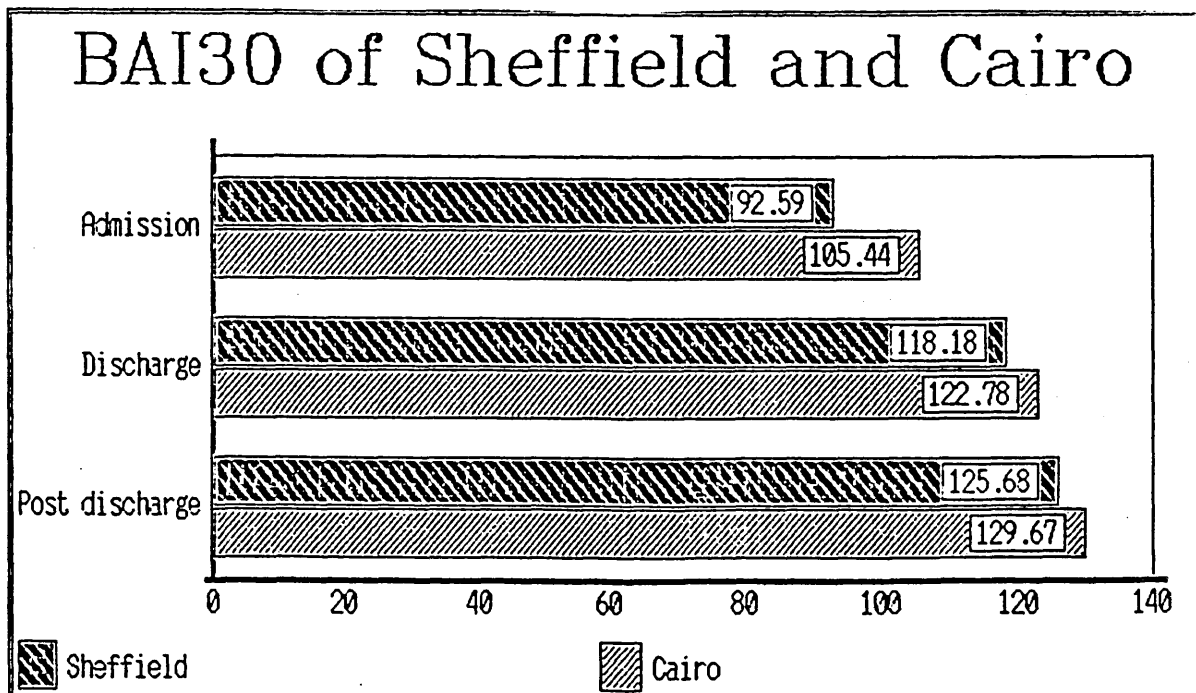


Figure 5.4: BAI_{30} of both groups in Sheffield and Cairo

The consistent tendency for improvement as presented in Figures 5.3 and 5.4, shows a parallel relationship between the GHQ scores and the BAI₃₀ scores. This feature was almost identical to the Cairo sample.

Despite the well-known fact about individual and cultural differences in the samples, yet individual cases showed a tendency toward general similarities in behaviour. A descriptive study of individual cases will perhaps help to explain the statistical outcomes and to do this a qualitative approach to data analysis was used.

5.4 The Qualitative Findings

Methods of data collection in the current study have included in-depth interviews and participant observation techniques in addition to the questionnaires and rating scale.

The use of both quantitative and qualitative methods was discussed. Data collected by means of in-depth interviews and semi-participant observation were used not only to provide detailed information about the subjects but also to provide a clear explanation of the quantitative results which may be regarded as suspect until the reasons for the discrepancy are well understood. Hagan (1986) favoured the use of in-depth interviews over the traditional ways of interviewing. She found through her study that real problems and unbiased data can be obtained when a "phenomenologically-based approach to interviewing" is adopted. Campbell (1979) stated that the case study approach is the dominant mode of study in anthropology, comparative political science and comparative sociology. Therefore the use of a case study approach in this study seems viable. According to Bell (1985), a practitioner case study could be seen through three paradigms; first, in terms of organisation which includes

short-term single site (including individual and group inquiry) and multi-site (networks of practitioner case study researchers); exploratory (in order to promote comparability and applicability); and insider (where the standpoint of the practitioner will predominate). Second, in terms of structure which distinguishes between case data, case record, case study, case report and case history (case study here refers to the critical portrayal of the instance grounded in the case record). Third, in terms of standards, ie case studies' ability to forego science and eschew rigour in revealing relations and enabling others to evaluate its practical meaning.

The concept of case study as used by Walker (1974) and Stenhouse (1978) had a clear set of four main categories: long-term/short-term, multisite/single site, insider-outsider, exploratory (concerned to provide authentic description) and exemplary (concerned to provide didactic comparisons).

According to the above concepts of case study approach, the current study has used the short term, multi-site, outsider, exploratory case study approach.

The following section presents four detailed case studies, two from the experimental group in Sheffield and two from the same group in Cairo; the reason four studies were chosen was to give an equal chance to the sexes as there is one study each of a male and female from each sample. A brief overview of the matched counterparts from the control groups is also included. The case studies are qualitatively analysed in terms of problems presented, therapy and intervention employed and evaluation of conclusions achieved. Pseudonyms are used for patient names to promote confidentiality. Intervention in each of these case studies employed the

FIA within the framework of the nursing process developed, as described in Chapter 3. The prescribed medication was maintained for all patients in both samples.

5.4.1 DETAILED CASE STUDY No 1 (Experimental group, Sheffield fieldwork)

Personal information and reason for admission (Source: hospital record and patient)

The patient's name is Geoffrey Raymond, aged 47 years (1983), married with 3 children by his first marriage and two children belonging to his current wife. He works as a police officer. This was his second admission to a psychiatric unit; the first was in 1978, after the break-up of his first marriage. The second admission was in early February 1983, as a result of his intolerable behaviour both at work and at home. He would occasionally resort to alcohol abuse as an escape from his problems but when he gets drunk he becomes very aggressive and physically violent, especially with his wife and with people detained at the police station. He was considered to threaten the safety of those people and so was referred by his boss at work for psychiatric treatment. He was accepted for in-patient treatment after an outpatient interview.

Presenting picture (Source: hospital record)

On admission he was noticeably tense, unable to sit down, talking very quickly, smoking excessively and talking aggressively to his wife who accompanied him. He denied the need for any psychiatric help and said that he understood his problems and was capable of handling them.

Development of the problem (Source: hospital record and consultant)

Geoffrey was previously married to another woman and had three children from that marriage, two daughters and one son. The three children are now grown up, the youngest (the son) being now 16 years old. The eldest daughter is married but the other two children live with their mother.

He was extremely unhappy with his first wife; he blamed his mother-in-law for

ruining his marital life by her interference. He began to feel very lonely and extremely unhappy. He began to avoid his home for long periods, either by staying at work for 24 hours or by going to pubs and getting drunk. During that time he met his current wife who also was married at that time and who had two children. With time the problem became more complicated when he began to behave aggressively at work. He was admitted for psychiatric treatment but he did not co-operate with the therapy, denied the need for psychiatric treatment and bottled-up all his feelings and problems. He considered admission or receiving psychiatric treatment as a stigma. However, this break and rest in hospital helped him to get better, to feel less tense and able to manage his problems.

After discharge he got divorced from his first wife and married his current wife, who also had obtained a divorce. However the situation was not resolved but became further complicated. His ex-wife kept his children with her but he missed them a great deal; each time he went to visit them or asked them to visit him he faced the disapproval of both wives.

He began to feel extremely guilty for depriving his own children of his care whilst his step-children were enjoying his care and financial support. To overcome these guilt feelings he began to spend his money foolishly on his children. This behaviour upset his current wife who felt that he was treating her and her children as a second-class family. Due to this complicated situation Geoffrey began to escape again by drinking too much, working too much and becoming verbally and physically aggressive. Thus a second admission became necessary.

Family Background (Source: patient)

Geoffrey had married twice; his first wife was a physiotherapist with a strong

personality and very domineering. She used to listen to her mother, who interfered in their lives and ruined their marital life. His children became distant from him and took their mother's side.

He became emotionally involved with his current wife, who works in the social services. She is very pretty and also has a strong personality. She was also married when they met and has two children.

Both Geoffrey and Pam (current wife) were able to get divorced from their partners and marry each other. This behaviour hurt his ex-wife who then used the children as a means of damaging his new marital life. Geoffrey was very hurt when his eldest daughter got married without inviting him to the wedding; she had not spoken to him since his marriage but behaved as if he was dead.

His mother is still alive and he visits her quite frequently.

Social and Environmental Background (Source: patient and wife)

Geoffrey explained that his social behaviour is completely the opposite of that of his childhood period. He used to be very shy and introverted, did not participate in group activities, although he loved football.

His personality and social behaviour began to change when he joined the police force. He began to participate in all kinds of sports and body-building activities and became rather violent. At the moment he still enjoyed the same sort of activities but had few friends with whom he could go golfing or for a social drink, which tends to make him drunk.

His current wife saw him as behaving in a very childish manner, very much seeking attention, lacking proper social manners and embarrassed her with her female friends. He liked to feel strong and important and loves to be in company all the time; gets annoyed very easily if she spends some of her time looking

after the children or doing the housework.

He treated his wife very badly during the drunken episodes, even to the degree of hitting her, which resulted in a back problem (for which she received treatment) and a black eye. In addition, his sexual relation was never very good as the side-effects of the psychotropic drugs and alcohol had affected him.

His relationship with his step-children is quite good in general, apart from the occasions when he gets drunk and frightens them with his aggression and violence. With his own children he is completely affectionate and spoils them by buying them a lot of unnecessary expensive presents. He is completely passive with his children or his ex-wife but behaves badly to his new wife and her children and was unfair in asking Pam to be patient with them when he was causing the difficulties.

Work situation (Sources: patient, consultant and hospital records)

Geoffrey worked as a police officer. He served there for twenty years in the operational field. In 1979 when he had the first episode of depression, he became very aggressive with one of the detained prisoners and could almost have killed him. He was considered unsafe and transferred to administrative work after discharge from hospital care. Geoffrey did not enjoy his new work and as he got no satisfaction from it, he asked to be transferred back to the operational field. According to Geoffrey, his request was refused because of the stigma of mental illness and admission to hospital for psychiatric treatment. He described his boss as not being understanding and very difficult to convince. Geoffrey found himself trapped in a boring job and at the same time he was having difficult family problems. He thought of taking early retirement on medical grounds and taking work in a solicitor's office.

Psychiatric Assessment

Geoffrey was diagnosed as having anxiety/depression with episodic alcohol abuse,

aggression and family problems. These problems were manifested in the following disorders, as assessed by the BAI30

1. Very tense, restless, unable to sit down, talks very quickly, smokes incessantly, stopped his wife from speaking quite aggressively; she suffered back problems as a result of being hit by him; denied having any psychiatric problems and refused to let others interfere in his affairs saying that he is quite capable of managing his own problems.
1, 3, 4, 6, 7, 9
2. Bottles up his feelings, refuses to talk about his problems; gets very aggressive and violent without being aware and does not control his behaviour; feels guilty about everything and wishes himself dead as everybody would be better off without him. He does not have suicidal behaviour. He was unable to plan a resolution to his problems or to know what he wants.
10, 11, 14, 15, 16, 17, 28
3. He used to spend his money foolishly causing problems for himself and his new family and did not look after household affairs but instead would go off to play golf all day. He was unable to remain fair to his two families and was unable to solve his family problems. He denied having any psychiatric problems and refused medical help and also refused medication at first. He had problems in adjusting to his new job and considered it boring.
25, 26, 27, 29

Treatment Plan

The main outline of the therapeutic plan was formulated by the consultant. The rest of the therapeutic team and the researcher were able to outline the details of the plan and its implementation.

The plan consisted of the following:

1. Encourage GR to talk about his problem, acknowledge his difficulties and accept help. This was to be achieved at first by the indirect approach, engaging him in suitable group therapy, eg communication, art projection, discussion group and Alcoholics Anonymous.
2. Individual therapy sessions would take place later in the programme when he was ready to develop insight.
3. Supportive psychotherapy was the main feature of the therapy at this stage, to help Geoffrey to cope with his uncertainty and feelings of guilt.
4. Encourage Geoffrey to take part in manual and physical activities to help him get rid of his aggression in a healthy, acceptable way.
5. Arrange for him to attend yoga classes to help him to relax, become less tense and restless.
6. Encourage social activities and outings, trust him not to drink alcohol.
7. Encourage the new wife to support and understand her husband's difficulties.
8. Insightful psychotherapy sessions to be on an individual basis.
9. Preparation for discharge and dealing with his work problem.
10. Community follow-up and family sessions as necessary.

Intervention Diary

1st session: Admission 2nd week of February 1983
Interview: Nurse in charge, patient and his wife
Problems: Violence, aggression, depression, alcohol abuse,

restless, anxious and denies his problems.

- Intervention:** Hospitalisation to ward 56
- Encourage him to accept hospitalisation and co-operate with the therapeutic team
- Introduce him to the wards and other patients and staff.
- Evaluation:** Patient accepted hospitalisation, but continued denying his problems, considered that hospitalisation in a psychiatric ward is a social stigma
- 2nd session:** 2nd week of February 1983 (same week)
- 1st interview:** First contact between GR and NM in group therapy
- Problems:** GR took the therapist's role in the group, asking everybody about their problems including the other patients and therapists. Denied his problems saying that he came for a rest because of work pressures.
- Intervention:** Accept his wish not to discuss his problems in the presence of other patients.
- Make use of his attitude towards 'fathering' other people including the researcher by encouraging him to establish a better relationship.
- Ask him to contribute to the research project.
- Evaluation:** Geoffrey agreed to contribute to the project to help the researcher with her work.
- He enjoyed playing the 'father' role or the 'policeman' role who should look after the well-being of everybody and help/support them.

For the following two weeks Geoffrey was playing the same role, did not talk about his real problems either in group or individual sessions. However, the researcher was able to gain Geoffrey's trust by playing the daughter role. She

used to see him on a daily basis either during the different group therapy or a one-to-one basis. Another patient of hers was close to the age of Geoffrey's son. Geoffrey was very interested in talking to this person and established a close relationship with him. This was very useful to begin discussing his relationship with his son and other family members.

Geoffrey's BAI₃₀ assessment score was below 4 on the following items:

1, 3, 4, 6, 7, 9, 10, 11, 14, 15, 16, 17, 25, 26, 27, 28, 29

3rd session: 1st week of March 1983

2nd interview: GR with NM

Problems: Feelings of depression, tension and guilt following a phone call from his ex-wife accusing him of not looking after his children's affairs and of losing his mind.

Items: 1, 4, 9, 10, 14, 15, 17, 27

Intervention: GR needed support, acceptance and reassurance.
Needed a chance to talk openly about his feelings and problems and his reactions towards them.
Discuss with him what he can do to feel better.
Encourage him not to blame himself for everything but to evaluate the situation more objectively (Rational-emotive therapy).

Evaluation: Geoffrey felt very guilty after the phone call and blamed himself and considered himself not to be a good father. He felt less tense after discussing the problems with the researcher who reassured him that he had not done anything to be blamed for.
This was a very useful session as he started to be open about his feelings from then onwards.
The use of supportive psychotherapy in this session was also

very helpful.

Analysis of his problems, without the elements of disruption, and teaching him such techniques was useful in reducing his feelings of guilt.

4th session: 2nd week of March 1983

3rd interview: GR and his wife with NM in the ward

Problems: The new wife was visiting GR but complained about the long drive every day to come and see him. She referred to his drinking problem and aggressive behaviour. GR tried to deny having a drinking problem.

Items: As before

Intervention: This was the first contact between his new wife and NM so the discussion was short and not intensive. The wife expressed the need for support and acknowledgement for her efforts.

NM postponed discussing GR's drinking problem until he was ready.

Discussion focused on planning a schedule of visits that would allow her two days break each week.

Evaluation: Geoffrey's new wife was very pretty and attractive, had a very strong personality and in time showed genuine interest in him and love and affection for him. She agreed to continue supporting him and was pleased with the decision that she could take two days off as a break each week.

5th session: 2nd week of March 1983, the following day

4th interview: GR with NM

Problems: GR feels worthless and causing problems for everybody. He seemed not to have a drink problem but cannot control his

aggressive behaviour when he gets drunk

His daughter rejected him when she had married and did not invite him to the wedding

Feels guilty about not being with his children who live with his ex-wife and her mother

Worried that they will become dogmatic like his mother-in-law

Feels guilty depriving his own children of his love and care while providing his new wife's children with all his time and care

Does not have a specific plan to deal with these problems but was considering divorcing his second wife and going to live on his own or with his mother

Items: 1, 4, 6, 9,, 10, 11, 14, 16, 17, 27, 28

Intervention: Discussion focused on exploring the details of the above-mentioned problems

Reassure him and encourage him to think more positively
(Supportive psychotherapy)

Accept his feelings and encourage him to think of a realistic plan to solve his problems (Reality therapy)

Evaluation: Again supportive psychotherapy was the main line of this session

Geoffrey said that he wanted to die but did not want to commit suicide

Reality therapy was essential in this session to help him to take an active step towards solving his problems rather than maintaining suicidal thoughts

Geoffrey was open for the first time about all his feelings and thoughts. He agreed that he escaped from his problems by drinking and promised to stop getting drunk or being aggressive

During this period of hospitalisation Geoffrey was able to control his behaviour, participated in daily activities of the day hospital and the outdoor activities of the ward. He became less tense and showed clear signs of improvement. Nevertheless he continued being secretive about his problems and never discussed them openly in group therapy.

6th session: 3rd week of March 1983

5th interview: GR with NM

Problems: Hospital discharge, going back to work which he considered boring

Still feeling depressed and guilty

Unsure whether he can cope successfully with his family problems

Items: 14, 15, 16, 17, 27, 29

Intervention: Discussion focused on his real feelings towards his new wife and her children (Insightful psychotherapy)
What he can do to see his own children more frequently and to feel less guilty

Take two weeks sick leave on discharge from hospital and try to go for a long weekend holiday

Try to become more interested in his work and examine the possibilities of going back into the operational field

Evaluation: GR was pleased to be discharged

Agreed with the plan and welcomed the follow-up in the community

Community follow-up

7th session: 4th week of March 1983

6th interview: NM with GR, his second wife and her daughter

Problems: Geoffrey appeared tense but denied having any problems (everything is fine)

He asked NM not to mention anything about what he had told her of his feelings about his second wife

Arranged for NM to see his second wife alone to allow her to be open about her feelings

Was worried about what NM would write in her notes

Items: 1, 4, 9, 10, 14, 17, 26, 27

Intervention: Discussion of his wife's perception of the situation, problems and actions needed to be taken

Allow the wife to be as open as she needs about her feelings

Respect her complaints and acknowledge her suffering (Supportive psychotherapy)

Try to evaluate the situation with her and see what help could be offered

Evaluation: The session was more of a ventilation session where PR (the wife) was very open about her feelings and problems:

1. GR's relationship with her children

He treated them passively, with no affection or interest, but they were interested in him and showed him a lot of affection
2. His relationship with his ex-wife and his children

His ex-wife is very manipulative and phones him to complain about his duties as a father which ruins his marital life. He listens to his ex-wife and always feels guilty so to compensate he buys presents for his children, spending his money unwisely and not leaving enough money for his second wife to buy everyday necessities so

she has to spend all her salary to support the family

3. Geoffrey's personality is immature and insecure, needs company and attention all the time, is childish in his behaviour, very interfering, lacks social skills and embarrasses his wife with her female friends
4. His drinking problem is very complicated
He does not drink every day only occasionally but when he does he gets very aggressive and hits her and frightens the children
5. She is very worried about her future with him and is thinking of getting a divorce
6. Their sexual relationship is not very good, the medication had affected his sexual ability. This problem worries him a great deal
7. He is a very 'Victorian' man, does not accept criticism and does not discuss his problems with her

During this time Geoffrey was sitting in the other room, very irritable and restless and intruded several times. To calm him down, at the end of the session he was asked to come in and the first family therapy session took place. His wife, in a diplomatic way, said that she was complaining about his aggressive behaviour and the drinking problem. These two problems were discussed again with him present. He promised to keep away from alcohol and treat his wife to a journey to Wales for a week's holiday without taking the children, leaving them with his mother.

8th session: 3rd week of April

7th interview: NM with GR and his wife at their house

Problems: Unhappy at work

Items: 29

Intervention: Discussion focused on:
Evaluation of the previous problems revealed and his coping mechanism at work

Evaluation: Both GR and his wife were more relaxed and more satisfied with their shared life. They had enjoyed their holiday in Wales. He was more cheerful, less guilty with the improvement in relations with his wife. However he complained about being bored at work. They accepted NM's invitation to a dinner party at her house.

9th session: 3rd week of May

8th interview: NM with GR and his wife. The dinner party involved a number of other patients both male and female. The patient who used to have a close relationship with Geoffrey was invited. After the party had finished and the other patients had left, the following session took place with GR and his wife.

Problems: PR, the wife, was very dissatisfied with Geoffrey's social behaviour during the party. He had a lot to drink although he was going to drive back home. He talked a lot and asked personal questions of other guests at the dinner party. He talked most of the time to the patient he had been close to, giving no chance for others to talk. He should also not have brought a bottle of wine with him in the first place because NM does not drink wine, so this behaviour could have given offence as everybody else drank only soft drinks.

Items: 3, 4, 6, 16, 17, 26

Intervention: Try to calm down the atmosphere.

Support the wife in her complaint

Ask Geoffrey to evaluate his behaviour (Insightful psychotherapy)

Encourage him to be more observant of his social behaviour (Reality therapy)

Evaluation: Geoffrey tried to rationalise his behaviour and accepted his wife's criticism. Asked his wife to drive back home. Agreed to stop such unacceptable behaviour. The dinner party was useful to assess G's social behaviour. His wife needed to be supported on her point of view. GR needed to develop insight into his behaviour.

10th session: 3rd week of June 1983

9th interview: NM with GR and his wife at their home

Problems: Great problem had occurred between Geoffrey's ex-wife and his second wife because of the following:

1. GR invited his daughter and son to spend a day with them. PR prepared a big meal and gave them a very warm welcome. The daughter never talked to her, ignoring her presence. After the meal Geoffrey took his children to play games and did not involve his wife or her children.
2. On another occasion his ex-wife phoned at home, ignored PR completely, requested more money and ordered GR to send for a doctor to come and see his son who had a high temperature.
3. The third time was in a supermarket where both PR and his ex-wife came face to face. His ex-wife insulted PR and spoke to her using very bad language.

However Geoffrey was very passive about all these incidents and did not protect his present wife and caused great

embarrassment.

Items: 25, 26, 27

Intervention: Discussion focused on:

- Ways of avoiding confrontation
- Encourage PR to be more patient and ignore them as well
- (Supportive psychotherapy)
- Encourage Geoffrey to be more assertive with his ex-wife and be sensible about spending money

Evaluation: The situation was difficult to deal with

Support and encouragement were given

11th session: 3rd week of June 1983

10th interview: NM with GR at the hospital

Problem: GR came without an appointment complaining of

- feeling worthless at work and could not face it any more. He feels very bored with sitting all day doing nothing. He feels redundant. He wanted to return to his operational field but his boss is not understanding and his medical record is a stigma, so his request is not supported
- Geoffrey very anxious, restless and desperate for help

Items: 29

Intervention: Encourage him to talk about this problem with somebody who can take action to help him, his consultant, or the sergeant (his boss)

- Examine other alternatives such as early retirement
- Contact his GP and obtain 2 days rest to calm him down and give him time to think things over again

Evaluation: Geoffrey chose to speak to his wife to discuss this problem with her

Agreed to take 2 days off work

Promised to study problem again when he is less tense

Returned to work after two days off

12th session: 4th week of June 1983

11th interview: NM with GR at her house

Problems: GR came to NM without an appointment.

Feelings of tension, irritability, restless

Feels trapped between his problems at home and problems at work

His wife, PR, supported his decision to take early retirement on medical grounds but he considers such action as cheating and stealing Government money

His wife had an argument with him because he started drinking again

He came to see NM without telling his wife who was very worried as to where he had gone

Items: 14, 15, 16, 17, 27, 29

Intervention: Phone his wife immediately to tell her about his visit to NM

Ask GR to speak to her and apologise for his irresponsible behaviour

Use reality therapy approach to help him behave more responsibly

Ask him to make an appointment to see his consultant and to start a course of Disulfiram (Antabuse) to deal with the alcohol problem by means of a conditioning process

Explain to him that retirement on medical grounds does not exclude psychological disease

Encourage him to discuss this with his consultant

Evaluation: GR's wife described his behaviour as childish which was true, especially on this occasion.
She was very worried about his drinking
GR agreed to carry out the suggestions proposed
He met his consultant the following week and began a course of Disulfiram
His wife supervised its regular administration

13th session: 3rd week of July 1983

12th interview: NM with Geoffrey's wife, PR (on the phone)

Problems: GR stopped taking the Disulfiram saying he could control himself without medication. One night they had had a party in their house with a group of friends. Geoffrey started drinking, became drunk, started to get aggressive and hit PR when she tried to stop him from behaving in a silly manner, giving her a black eye.
He does not go to work regularly, does not make any decisions and gets days off through his GP
Spends his days playing golf

Items: As before

Intervention: Discussion focused on the previously-mentioned problems.
Asked her to encourage him to take the Disulfiram again
Suggested she ask the consultant for an appointment to come and see both of them

Evaluation: PR was very upset at Geoffrey's behaviour, needed support and encouragement
Was thinking of getting a divorce
Agreed that both should come to see NM as soon as possible
Arranged an appointment also with the consultant

14th session: 1st week of August

13th interview: GR and his wife with NM at the hospital

Problems: As before

Items: As before

Intervention: Reality therapy and insightful therapy were the main approach of this session

Support was given to PR

Discussion focused on:

- evaluating Geoffrey's behaviour, encourage him to gain insight to his motives and behaviour
- his drinking problem was openly discussed, with much disapproval of his irresponsible aggressive behaviour
- both Geoffrey and Pam agreed to discuss their financial difficulties and find an outlet for GR for when he retires the following month

Evaluation: Geoffrey accepted the critical evaluation of his behaviour
Agreed to take Disulfiram regularly and start planning his occupational perspective after his retirement (had considered working in a solicitor's office)
Geoffrey suggested moving to a smaller house thus paying less mortgage and PR agreed
Geoffrey was able to recognise his emotional behaviour and was less defending of this behaviour

15th session: 1st week of September

14th interview: GR with his wife and NM at the hospital

Problems: PR was very angry with Geoffrey as he had forgotten to pay the bills for electricity and gas, which had been cut off for two days
He was fully pre-occupied with playing golf and had not forgotten to pay his membership for the golf club

He also bought himself a new car which was more expensive to run than his previous one

He had paid for his children to go abroad for a holiday

Despite all this unwise spending, he wants his wife to move to a smaller house which is unsuitable for the size of the family and their furniture

Items: 3, 4, 6, 7, 9, 10, 11, 14, 15, 16, 17, 25, 26, 27, 29

Intervention: Open discussion was encouraged. Both Geoffrey and his wife were able to express their feelings of anger and frustration. They were very critical of each other's faults. Geoffrey explained that he still feels guilty for losing his children, Pam explained that she feels very insecure and threatened that any minute he may leave her and go back to them.

Pam was very emotional during this discussion and started crying, which encouraged Geoffrey to be sympathetic and affectionate to her.

After this angry storm, the discussion focused on logical steps for solving the problem (Family therapy).

Evaluation: This was the most successful therapeutic session as a lot of the misunderstanding and frustration was revealed. For the first time they were able to talk to each other about their fears and real feelings.

Better understanding was achieved by the end of the session.

Both were able to come to an agreement on the following steps to solve their problems:

1. Geoffrey would be allowed to spend as much time with his children as he wants, Pam should be more tolerant and patient

2. Geoffrey should start work and save the money received from his retirement in the bank to gain interest which he could then spend
3. Pam will not move from her house and will receive a fair share of his attention
4. Geoffrey will continue taking the Disulfiram to avoid recurrence of his drinking problem
5. Pam would be prepared to receive Geoffrey's children in her house and to ignore their awkward behaviour

This plan worked all right for the rest of the follow-up period. Termination of the follow-up period took place in the 3rd week of October 1983.

Table 5.10: Summary of BAI₃₀ Assessments for Geoffrey RaymondBAI₃₀ Assessment on admission, discharge and end of follow-up

Item No	Section	Statement	Problem presented	Score		
				Admission	Discharge	End of follow-up
1	Communication and social skills	Non-verbal communication	Very tense, restless and talks quickly	2	4	5
3		Waits for turn to speak	Stopped his wife talking, intrudes during conversation	2	3	5
4		Talks about self as appropriate	Takes the figure of father or therapist while talking to others	2	3	5
6		Attentive listener	Preoccupied with defending himself	3	5	5
7	Insight	Live with others on peaceful terms	Very aggressive and violent when gets drunk	1	3	4
9		Accept success and failure	Does not accept failure and refuses to adapt	2	4	5
10		Discuss personal feelings	Bottles up all his feelings	1	4	5
11		Awareness of negative feelings	Lacks recognition of negative feelings and behaves impulsively in aggressive manner	2	4	5
14	"	Realistic appraisal of current problems	Denies having problems	2	5	5

Item No	Section	Statement	Problem presented	Score		
				Admission	Discharge	End of follow up
15	"	Self confidence	Considers himself worthless and wants to die	2	4	4
16	"	Short/long term achievement	Lacks sensible expectation of himself and others	1	4	5
17	Insight	Dealing with problems	Escape facing problems by drinking	1	3	5
25	Self and family care	Management of finance	Spends money foolishly	1	3	4
26	"	Personal and family everyday responsibility	Does not participate with his wife in sharing this responsibility	2	3	4
27	"	Deal with family problems	Subjective, unfair and escapes facing the problems	1	3	4
28	"	Seek medical help	Refused medication or hospitalisation	2	5	5
29	"	Work duties	Could not adjust to his new administrative job	2	3	5

Researcher analysis and impression

Geoffrey's problem had several dimensions; to start with there was his personality and the escape mechanism and denial of his problems and difficulties.

He needed support and acceptance as it was very painful for him to feel rejected by his own children whom he loves a great deal. His ex-wife was not very understanding and on the contrary she increased his feelings of guilt and manipulated him financially and was also trying to ruin his second marriage. His second wife was feeling very insecure and very jealous of his children and ex-wife. She was always comparing what she received from him with what his first family received and pressure was therefore building up daily. Geoffrey bottled up his problems and did not ask for help. He lacked clear insight for his behaviour and motives and was unable to behave responsibly so that he appeared selfish and sometimes childish. His problems began to improve when he talked and discussed his problems openly and was able to accept criticism and develop insight. Pam's support and understanding was essential to help him regain a stable life. Their relationship was clearly improved after the last therapeutic session when each of them was able to verbalise his and her problems in a secure controlled environment. The therapist's presence was thought to be useful.

5.4.2 DETAILED CASE STUDY No 2 (Experimental group, Sheffield fieldwork)

Personal Information (Source: hospital records and patient)

Julie Allen, a female patient aged 28 years (in 1983), single, lives on her own in a single bedroom flat in Sheffield. She left her family home in Eastbourne four years ago. This was her second admission to a psychiatric hospital; the first admission was in Eastbourne four years ago, after an excitement episode when she had got drunk one night at a party in a night club. She works as a nurse in one of Sheffield's hospitals, on night shift duty.

Presenting picture (Source: Consultant, patient, own observation)

Very depressed, constantly weeping, sleepless, anxious and tense, cannot relax on a chair or during any conversation. She requested hospital admission after advice from a psychologist whom she used to see professionally. At first she expressed her worries over informing her parents about her admission to a psychiatric ward but eventually agreed.

She complained of having very sad thoughts on her mind, feels worthless and wants to die, but she did not want to commit suicide as it is a sin.

Development of the problem (Source: Consultant and patient)

Julie came from a very religious family background and was brought up in a very strict narrow religious faith. They denied her the need for physical pleasure and considered sex as wicked and dirty. As a child they would lock her up in her room for hours if she did anything wrong, eg not putting her toys back in their place or having a temper tantrum.

The terms 'good' and 'bad' were used excessively to judge her behaviour as a child. This sort of treatment was not applied to her younger brother and sister when they were naughty. She felt rejected and hated by her parents and she bottled up

all these feelings.

She found escape from her family situation through a small group of female friends. One night they went to a night club to celebrate a birthday and Julie got drunk and lost control over her suppressed feelings of hurt and anger. She got very excited and smashed things up at home. Her parents described her behaviour as evil and she was admitted to hospital for treatment for a few days. She managed to escape from her family situation and social pressures and got a job in Sheffield as a nurse on night duties.

Family background (Source: patient)

Julie is the middle daughter of her family and she has one elder sister and younger brother, both of whom are married and her sister has a baby son.

Her parents are very strict Catholics and place a great emphasis on the need to behave well in order to be loved. However, they did not show their love to her in practical terms such as kissing or cuddling her. Her brother and sister were allowed to misbehave but she always had to be ideal in her behaviour and to set a good example to her younger brother and elder sister. She has never seen her parents kiss each other, although they said that they love each other. They always behaved in a very polite manner and stressed that she should do the same and always feel happy.

Social and environmental background

Julie is pretty, very clean and tidy and dresses very well; however, she has never had a boyfriend and does not think she can have one. She does not expect to get married at any stage as sex is dirty and she is over-obsessed with cleanliness and tidiness. She has a few friends in Sheffield but she does not receive them at her flat as she cannot bear the thought of disturbing the tidiness of her flat. She goes out with them for social evenings in pubs or for meals, but not all the time as she cannot afford it. She enjoys solitary types of activities such as playing

the guitar and reading novels.

Religion and faith: Catholic, believes in God, always observes Him in her behaviour. Believes she will be severely punished for any misbehaviour.

Work situation: (Source: patient and consultant)

Julie is a qualified nurse and has worked in general wards since qualification. During the last four years she has worked on night shifts only. Julie regards her job as very difficult and thinks it puts her under great stress, especially in decision-making in critical situations.

Psychiatric assessment

Julie's diagnosis was anxiety/depression in an obsessive personality. The hospital plan of intervention used the psychodynamic model with the help of minor tranquilizers and antidepressants.

Technique used by the hospital:

1. Involve Julie in suitable group therapy
2. Provision and supervision of medication intake
3. Key worker involvement in the individualised treatment sessions run by the researcher.

The psychodynamic approach was carried out both by the hospital team in the form of group therapy and the researcher who contributed to the group therapy plus individual therapy sessions.

Problems identified using the BAI Assessment Instrument

On admission BAI₃₀ scored below 4 on the following items:

Numbers 1, 2, 7, 8, 9, 10, 12, 14, 15, 16, 17, 18, 27, 29.

These items were represented by the following features:

Signs of tension in face, hands and legs, unable to relax while sitting, squeezing into the side of the chair, speaking in a very low voice, looks down and does not initiate conversation.

Avoids other patients, sitting alone most of the time on her bed. Very weepy and sad most of the time.

Behaves very politely to everybody regardless of her real feelings and finds it difficult to say 'no'. Always afraid of making a mistake as she wants always to be a 'good girl'.

Items: 1, 2, 7, 8, 9

Suppresses her feelings towards her parents, does not allow herself to admit her anger towards them and considers this a sin.

Escaped from her unhappy family situation, bottled up her feelings more and more and does not work out a plan to get rid of these miserable feelings.

Does not accept sex and thinks of it as dirty.

Finds her job very stressful with a lot of decision-making

Items: 10, 12, 14, 15, 16, 17, 18, 27, 29

Treatment Plan

Consultant, nurse (key worker) and NM with Julie developed the following plan to help Julie to deal with her problems:

1. Encourage Julie to talk freely about her feelings and express them in writing first, then on a one-to-one basis, and then in group therapy
2. Help Julie to develop her assertive skills, to mix with other patients and

join social activities

3. Arrange for Julie to attend psychodrama and art therapy groups + individualised therapy sessions run by the researcher, based on psychodynamic approaches, FIA and the nursing process
4. Encourage Julie to learn about healthy ways of expressing anger
5. Consistent and continuous provision of care and support by the staff, regardless of the nature of the emotions expressed
6. Encourage and teach Julie to deal with her feelings in a constructive way
7. Help her to get a less stressful job after her discharge from hospital
8. Community follow-up and long term plan arrangements

Intervention Diary

Admission:	end of April 1983
1st interview:	Psychiatric consultant with the patient, ward sister and the researcher
Problems identified:	JA very depressed and weepy, tense, unable to sleep or relax
Intervention:	Informal admission, minor tranquilizers, close observation. Encourage the patient to talk about her feelings
Evaluation and outcomes:	Patient continued to be weepy, accepted hospitalisation, worried how her parents will react to her hospitalisation, agreed to inform them the following day
1st session:	Following day of admission, end of April 1983
2nd interview:	JA with NM
Problems:	JA very sad, very weepy, remained by her self

	most of the time, claimed not to understand what is wrong with her, feels agony and pain and feels the need to cry
Items:	Were left to be identified in following session
Intervention:	Acknowledge Julie's depressed state and help her to recognise the real problem (Supportive psychotherapy) Encourage her to write or draw her feelings (Insightful psychotherapy) Encourage her to talk to other patients on the ward Ask Julie to participate in the research project and to fill in the questionnaire
Evaluation:	JA agreed to participate in the project and filled-in the questionnaire, promised to try to write down her feelings
2nd session:	1st week of May
3rd interview:	JA with NM
Problems:	As before, and additionally, JA expressed some of her negative feelings towards her parents in her writing, eg: she did not feel loved by her parents but felt rejected as a child; her parents used to lock her up when she misbehaved or had a normal childish tantrum; as a child she was always afraid of being locked up in the dark (aged 2 years), to have to face all the fear and confusion alone; as an adolescent she was always afraid to misbehave and of not achieving her parents' expectations
Items:	1, 2, 7, 8, 9, 10, 12, 14, 15, 16, 17, 18, 19, 27, 29
Intervention:	Patient was encouraged to talk about these feelings and reveal the threatening, painful events of her

childhood

Support and acknowledge her suffering

Encourage her to do more writing and painting and to participate in psychodrama and art therapy groups in order to enable her to express her feelings more spontaneously (talking therapy) Selected examples of JA's drawing and writing are provided at the end of this case study.

Evaluation: Julie continued to be weepy and expressed feelings of pain and agony over remembering these events Expressed feeling of being desperate for help, appreciated talking to the researcher, claimed to feel better after the session. Agreed to play the guitar, with another male patient, for a group of patients on the ward

3rd session: 2nd week of May

4th interview: JA with NM

Problems: As before

Items: As before

Intervention: Encourage Julie to join yoga classes and anxiety management in the day hospital
Discuss further writing and painting with her
Help her to be open about her feelings
Accept and respect her need to cry
Encourage her to accept that she has negative feelings towards her parents

Evaluation: Julie talked more, giving further details about her parents; but it was too painful for her to see that she has negative feelings towards them. She explained how they had treated her differently from her sister and brother

and how she was not allowed to mention her likes and dislikes, and was expected to feel happy all the time. Smoking, drinking and sex were considered evil and she must not pursue them

She had learned to suppress her feelings and ignore her needs; however she did smoke heavily

She explained that her writing and drawing had shown her the amount of hate she had towards her parents. However she felt very guilty about this and agonised about it. She was afraid to lose the support of the researcher and staff once she had disclosed her real feelings of hate and anger towards her parents.

Staff and researcher continued consistent support and interest

Julie was able to start a close friendship with two other female patients of her age and regularly attended the different groups

4th session:	3rd week of May
5th interview:	JA with KM (her nurse key worker) and NM
Problems:	Suppressed anger with great difficulty in expressing it in open terms
Items:	14, 15, 16, 17, 27
Intervention:	JA agreed to take part in a role play with KM (male psychiatric nurse) as her father and NM as observer and helper in initiating and keeping the dialogue going The subject was 'Facing her parents with their unkind behaviour towards her, resulting in having negative feelings towards them' KM, as her father, asked Julie what he had done

wrong to make her feel so angry with him

Julie gave a list, with much bitterness, tears and anger, of all kinds of punishment she had received as a child and how these had made her extremely unhappy, nervous and insecure. 'Dad' defended himself by saying that he was teaching her 'good' behaviour and nice habits.

At this point Julie broke out in a storm of anger, comparing his way of dealing with her against that for her brother and sister, telling him how jealous she felt of them both and how hard she had tried to get his attention and love by being a model child but he had taken no notice. He did not love her, she even accused him of not knowing how to love: he even failed to love her mother, both of them only pretended to love each other but they were really only 'acting' and that they escaped from that failure by trying to become 'religious', but this was only a pretence not a genuine intention to love God.

KM, as 'Dad', was shocked, confused and not able to defend himself. Very keen to have Julie back in the family, he asked her to forgive them and to make a new start; to give them a second chance to show their real love and concern for her. Julie was stubborn, persisting in baiting him and appeared to enjoy watching him suffer as a result of her rejection and lack of acceptance.

Evaluation:

Julie was very pleased with her achievement, enjoyed the success and power, claimed to feel relieved from such suppressed feelings which had troubled her for years. However, she did not feel completely free of these feelings as the situation was not a 'real' one, and that she

would never be able to do it in a real situation.

She was able to talk about this experience with other patients and staff.

5th session:	4th week of May
6th interview:	JA with NM
Problems:	Julie became verbally aggressive towards KM, her keyworker (upbraiding him as a parent)
Items:	8, 10, 12, 14, 15, 16, 17
Intervention:	Discussion focused on: Her reason for this behaviour Her real feeling towards KM as keyworker and as a 'Dad' in the role play His reaction towards her aggressive behaviour and how she felt then
Evaluation:	Julie was happy with this experience, pleased with KM's understanding and patience and that she did not lose his support because of her bad behaviour She explained that she had to do that because KM was urging her to do as her father used to do in the past. The result was that her emotional tension was considerably relieved for some time following this incident
6th session:	1st week of June
7th interview:	JA with NM
Problems:	Feeling miserable again, weepy , suffering from the same pain and agony
Items:	As before
Intervention:	JA was asked to draw her parents and to do whatever she wanted with them. After drawing a picture of them,

she tore the picture viciously into small pieces, expressing great anger with them.

At the same time she realised that she both needed and wanted them and that she could not live without them. So she collected up the pieces of paper and started crying and apologising for what she had done.

Evaluation:

This session was helpful for Julie to realise that she did still have positive feelings towards her parents and that she wanted to forgive them and enjoy their love. She agreed to start thinking more positively about her parents and would try to leave the 'vicious circle' of the process of ventilating her feelings, then feeling guilty and miserable, then receiving compensatory love and attention from the staff and other patients.

She was asked to write a letter to her parents and to list down what she felt she needed in order to help them to have a new and better relationship. This letter was not to be sent, but to be given to NM

7th session:

1st week of June (same week)

8th interview:

JA with NM

Problems:

As before

Items:

As before

Intervention:

JA was asked to bring a photograph of her parents and to read the letter to them.

Julia looked at the picture for a few minutes before she was able to read the letter to them.

She cried a lot and hid the photograph under a book. She looked at the photograph again and started talking to

them negatively, saying that they appear in the picture as if they are really in love and that they are happy, but to her they are not - they just pretend.

Julie was asked to put herself in the place of her parents and imagine what they would say in response to her accusation. Julie, as a parent, said they are really happy and want her to be happy as well, that they have made a mistake in the past but would like a fresh start as they cannot change the past.

Julie, as herself, again agreed that she could not do anything about the past, but she needed time and support to forget her painful feelings.

Evaluation: Julie became much more reasonable in expressing her feelings, began to face the situation and tried to think positively.

Julie was asked to write down her expectations regarding her future, which would be discussed in the following session.

8th session: 2nd week of June

9th interview: JA with NM

Problems: Julie was apprehensive because the consultant had asked her to go camping (an activity arranged by the ward). She could not refuse the consultant's advice but she could not stand the thought of the dirt she would have to cope with on camp.

Items: 8, 10, 16, 17, 29

Intervention: Discussion was focused on her reasons for not going and how to say 'no' in an acceptable manner

Evaluation: Julie took the decision not to go to camp and was

able to tell the consultant of this decision

She also wrote a plan for the future which involved the following areas:

employment; accommodation; contact with the family; social life; her obsessions and how to deal with them; self assertion and the need to express herself; and dependence/independence.

Some of her future expectations were not considered sensible by the consultant, eg Julie's expectation to stay in hospital for 6 months. However, her expectation to change her job from night shift work to working in outpatients was acceptable to the consultant and she promised to help support her application

9th session:	3rd week of June
10th interview:	JA with NM
Problems:	JA still tearful, the consultant had suggested she take some active steps towards discharge and to spend two weeks holiday with her parents after her discharge
Items:	7, 8, 9, 14, 15, 16, 17, 27
Intervention:	<p>Encourage Julie to phone her parents to arrange the holiday</p> <p>Encourage her take gradual discharge, as follows:</p> <ol style="list-style-type: none">1. Spend one day in her flat accompanied by the researcher, where she can carry out her usual everyday activities and try to carry out two types of therapy session during this visit -<ol style="list-style-type: none">a) to help her to overcome some of her obsessional traits of being over-obsessed with cleanliness and tidiness

A suggestion was made to disorganise a small corner of her flat, leave it disorganised for an hour, then tidy it up again

- b) free association session, to tape record her thoughts regarding herself, being back in her flat and what she would like to do in the future. This was in order for her to have the chance to listen to herself in the future and to develop more insight

2. Spend two intermediate nights in the following week in her own flat

3. Take action regarding her change of shift at work

Evaluation:

Julie agreed to spend two weeks of her summer holiday at her parents' home. She phoned them to make the necessary arrangements

She agreed for NM to spend the day with her in her flat; however she was frightened at the idea of some disorganisation in her flat and she refused this suggestion.

She agreed to tape record her thoughts for the 'free association' session

She applied to work as a nurse in an out-patient clinic

10th session:

3rd week of June (the following day)

11th interview:

NM with JA at her flat

Problems:

As before

Items:

As before

Intervention:

Join JA in her flat

Join JA in shopping on the way to the flat

Join in preparing a meal

Discussion focused on:

- her feelings about her discharge and being back in her

own flat

- her feelings towards her parents and visiting them for two weeks
- what she will do when she is on her own in the flat for 24 hours a day

Then the 'free association' session took place while she relaxed on her bed

Julie was asked to think and talk about how she feels being alone in her bed and what she would wish to make her happier

Evaluation:

Julie has managed very successfully to do her shopping, cook a balanced meal and spend her money reasonably.

Julie explained that she is anxious about the presence of NM in her flat because of what NM might ask her to do. She was feeling worried and afraid both of feeling lonely and of possibly being 'unable to cope'

Together JA and NM listed the strategies which she could adopt, for example:

1. buy or hire a TV set
2. get books from the City Library, as she enjoys reading
3. take a course in typing as she began to learn this in hospital
4. join Ward 56 outings
5. spend some time with her acquaintances
6. continue going to the church social evenings
7. further therapeutic sessions with researcher, home visits and follow-up.

Julie still expressed feeling 'in agony' and very worried about visiting her parents;but she decided to go ahead and give it a try.

The 'free association' session had to be abandoned as Julie was too anxious about the idea of recording her thoughts and had failed to record anything reasonable after half-an-hour's trial

In general this visit was very useful for both Julie and the researcher. It lasted approximately 5 hours. It became clear from the first minute in the flat that everything was meticulously tidy; also there was a large quantity of cleaning agents such as detergent, shampoo and washing powder, nearly over 20 different types. However, Julie refused any intervention with this problem as she did not see this as necessary.

11th session:	4th week of June
12th interview:	JA with NM
Problems:	Hospital discharge and the visit to her parents Change of work shift
Items:	As before
Intervention:	Discussion focused on: <ul style="list-style-type: none">- her experience of spending one night at her flat- buying a small present to take to her parents when she visits them- what she must do to get the job in the outpatient department
Evaluation:	Julie was less worried about visiting her parents after the consultant had spoken to them on the phone and explained to them tactfully the nature of Julie's problem

and how they could help.

Julie did not buy a present for her parents as she still felt angry with them and she wanted to be consistent with her feelings

The consultant wrote a letter in support of her application for the job which gave her more hope about the job.

There was no problem when she spent the night in her flat, apart from feeling sleepless at first.

She also had begun packing to take her belongings gradually from the hospital back to her flat.

She claimed to be ready for discharge by the end of the week.

She booked her ticket to visit her parents while she was still in the hospital, to travel on the day following her discharge.

Arrangements for a home visit were made to start the week following her return from her holiday.

The previous diary has dealt only with the therapeutic sessions of significance. Julie was seen daily by NM during the hospitalisation period either for informal chat, support, or joining in the different therapeutic groups. NM joined all the ward rounds held by the consultant where JA and her nurse-keyworker were; she also joined in when the theme of intervention was discussed and when the review of the plan of care took place. Julie joined intensive group therapy such as communication, art projection, psychodrama and anxiety management. She also joined other less intensive group therapy, such as a social skills group, yoga and ward outings to cinemas and pubs. NM participated in these sessions and activities. She also started to learn typing which she was keen to continue after her discharge. The consultant agreed that she could come and practise in her free time. Julie sent a card to NM while she was on holiday, saying that she had

had a warm welcome, was staying with her married sister, had visited her parents and felt better but not completely free from her anger.

Community follow-up

12th session: 3rd week of July

13th interview: NM with JA at her flat

Problems: This home visit was urgent after NM phoned JA and found that she had taken an overdose of Frisium and Anafranil, 21 tablets, the day before and had slept for 18 hours

Intervention: Inform the ward sister and the consultant
Immediate visit to Julie, check pulse and blood pressure
Gave her large quantities of black coffee.
Stayed with her for an hour to make sure she was alright.
Ask her next-door neighbour to keep an eye on her.
No stomach wash or hospitalisation was needed at this stage.
Question JA as to reasons for taking an overdose.
Took away all the tablets except 2 in case she needed them in the night.
Gave her some soup and a piece of toast to eat, provided by the neighbour.
Got a promise from her that she would not try to kill herself.

Evaluation: Julie claimed did not intend to kill herself.
Claimed felt very anxious and needed to sleep and so kept taking tablets until she slept. She knew she would be safe as one of her friends was coming to see her that evening, but as Julie was fast asleep and nobody else was at home,

he could not get in and left. She remained asleep until the following day when NM phoned her.

She expressed her anger towards NM, the hospital staff and the consultant in particular, as she thought they had wanted her to leave their care and interest too early and had sent her back to her parents. She admitted that she wanted to make us feel guilty and gain our attention once again.

She did admit that her holiday was very enjoyable.

She decided to write a letter to her consultant to say how she feels and how angry she is with her. NM made arrangements to visit her the following day, to ensure her safety.

13th session:	4th week of July
14th interview:	NM with JA at her flat
Problems:	Feeling worried about seeing the consultant especially after sending her a very angry letter
Items:	8, 9, 14, 15, 17
Intervention:	Discussion focused on: reasons of worry, her expectation, what she wants from the interview with the consultant, what NM can do to help
Evaluation:	Julie asked NM to accompany her to this appointment and NM agreed
14th session:	1st week of August
15th interview:	JA with the consultant and NM at the outpatient department
Problems:	As before
Items:	As before
Intervention:	The consultant was understanding about JA taking the

overdose and writing the rude letter but did not approve of such behaviour.

The consultant said would support JA if she needed help

Encouraged JA to try to sleep without sleeping tablets

Terminated follow-up and referred Julie to her GP

Evaluation:

Julie became less anxious after the interview was

over. She expressed feelings of rejection for being

referred to GP care.

NM explained that her community follow-up was still continuing.

Julie started work as a nurse in an out-patient department.

She bought a TV set.

She started a course in typing.

15th session:

4th week of August

16th interview:

JA with NM at her office in the hospital

Problems:

Feeling apprehensive about dealing with a lot of paperwork in her new job; this fits with her obsessive personality.

Wants to get better council accommodation.

Items:

29

Evaluation:

Julie wanted to change from nursing altogether to another type of job, such as secretarial work,so she has improved her typing.

This suggestion was not welcomed by NM.

Julie decided to see the hospital social worker to help her get a council flat.

Following this session the communication and follow-up of Julie was limited to phone calls and writing letters. Julie resigned from her work as a nurse, worked

in a housing department (clerical work); she was happy with her new work (which was made permanent one year later). She refused to see NM, claiming that she was very busy with her work and socialising with friends in the evening plus going to church.

In November 1983 termination of the community follow-up took place. Julie sent a letter of thanks to NM and claimed that she was coping alright and her relationship with her parents had greatly improved although from time to time she remembers the pain they caused her and that she is still a little anxious.

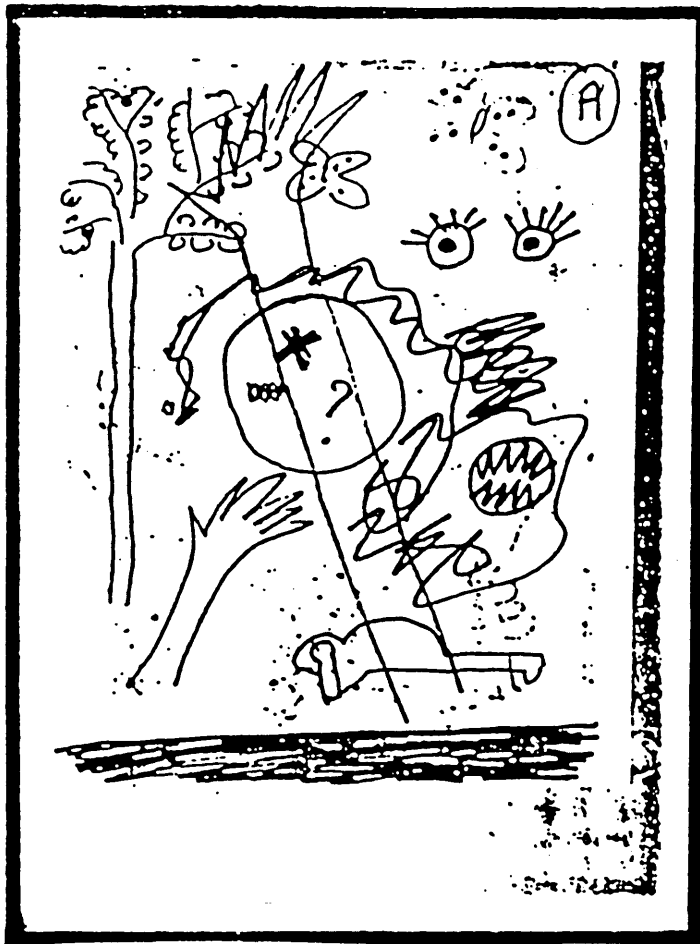


Illustration 5.1 Interpretative images:

(A) The Blackness of Death

'Blackness at bottom...death. Tree - no roots - no grounding. Confusion - darkness within... What is the meaning? What is life about? Guilt.

A figure lies parallel to the blackness - attempting to shut out the pain and confusion. Would death be preferable?

Two hands, reaching out, struggling to grasp on to something to sustain me - but there is nothing concrete to hold on to.

The red, angry hand trying to hold on to the tree, or to reach the butterflies which are a symbol of goodness and beauty. They are however, beyond my reach. I am furious because I can't attain them.

Two eyes...sad, staring, frightened and glaring. A mouth with black sharp teeth...a scream'.

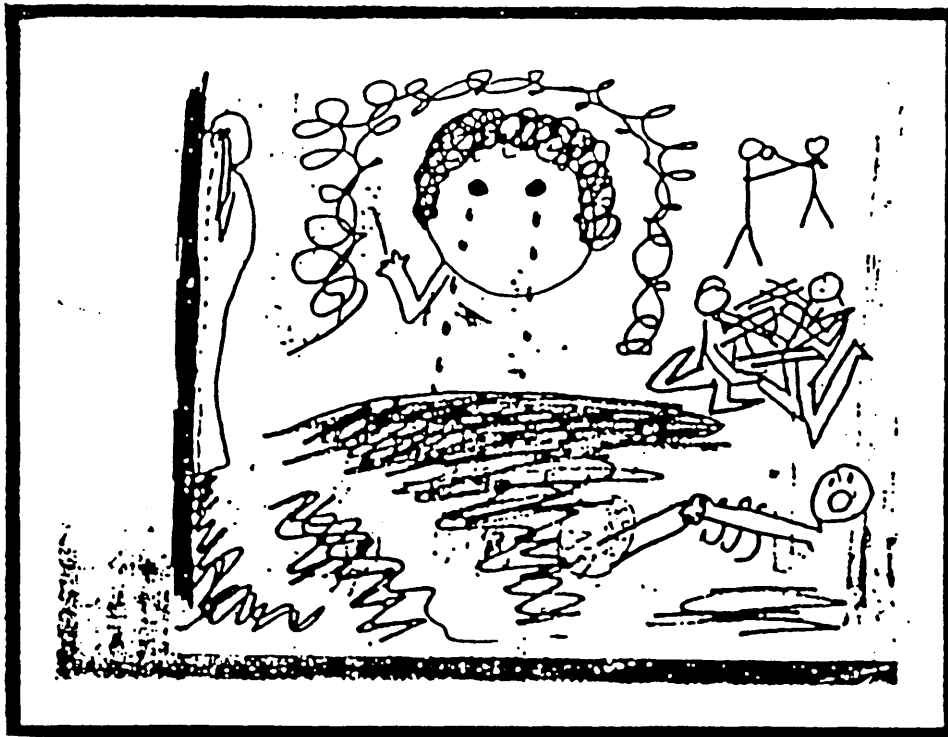


Illustration 5.2 Interpretative images

(B) The Sad Face

'Face with no body...sad eyes, weeping tears of blood. Grief about feeling destroyed, and being made to feel as if dying.

'Blackness at left of drawing...death. I am facing this black wall - crying blood there, surrounded by confusion and guilt.

'Fighting at the right of the drawing - boxing, wrestling, punching - with myself and/or with my parents.

'One hand pathetically reaching out to discover the goodness symbolised by the yellow flower, which must exist somewhere to keep me alive'.



'I find this drawing powerful. I feel it is sexual, and is a picture of the uterus being filled with blood. What represents the source of life - the womb - is being destroyed and torn apart. There is a fight going on - as if my parents are doing this to me - like having a 'tug-of-war' over me.

'I am crying tears which turn into death at the bottom. The heart shapes may represent goodness which is being obliterated - they are red and black and made horrible.

'The arrows may mean that I am taking all the pain inward, taking my anger into myself, hating myself and turning into an introspective, self-analytic person/child - this is a way of defending and coping with the onslaught.'

Illustration 5.3 Interpretative images

(C) The Torn Uterus

'The heart shapes have a chain joining them - my parents are trying to drag me into this deplorable entanglement, where I cannot have my own identity, but must carry their pain'.

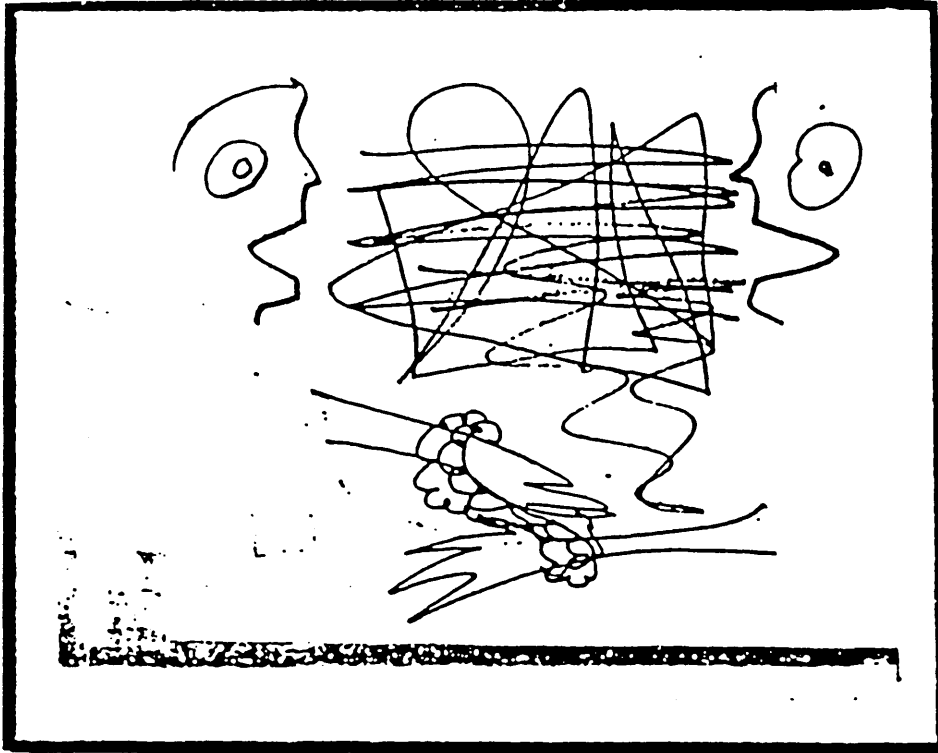


Illustration 5.4 Interpretative images

(D) Anger and Destruction

'I think the faces are those of my parents and their unconscious repressed feelings. This anger and destruction would occur if these feelings were known and expressed - hatred, loathing, rage and destruction of each other.

'Their hands are chained together beneath. They must be locked together in this bondage in order to avoid knowing that their real feelings exist'.

Julie's Expectation Regarding Her Future

My Feelings about being in Hospital and My Goals for the Future

- 1 I need to allow myself to accept my dependence on receiving help here; and believe this is necessary for at least six months as an in-patient and/or out-patient later on. I do not see this feeling of dependence as being on-going; but a temporary situation which will afterwards enable me to develop more fully as my own independent person: and I have positive goals in mind for 1984.

- 2 Employment

I am grateful for the feeling of security in knowing that I will not be turned away from my present social work post without help to find an alternative job, as my employers have indicated. I cannot at present decide whether another field of social work is a possibility; but am bearing in mind (names a speciality). Alternatively, I am aiming to learn to type; and should I

decide that secretarial work is realistic, I could pursue a secretarial course later, or the offer of a clerical post at the Glebeshire Hospital.

3 Accommodation

At present I rent a furnished flat. I hope to obtain a council flat sometime next year in the Hinderthorpe area, which would require furnishing, equipping, decorating, etc - and generally setting up a home for myself. I wish to live on my own, and see that as being right for me. I may need support to help me with all the anxieties involved in moving and in furnishing this flat. I want to stay in Sheffield for several more years: and don't have any future plans at present to move elsewhere.

4 Contact with my family

I feel that the time spent with my parents when they visited me here was instructive in that I was able to share with them honestly to a limited extent: and I feel we have gained a little more respect for each other, and acceptance by them of my need to maintain my own distance and separateness from them. I intend to keep in touch with my family: and should my parents need support from me later in their lives, I would offer what I can - but not in my sense at the cost of my own living. I need to be more truthful in my relationship with my parents, brother and sister; especially in asserting myself about when I want to visit them and when I don't want to visit them: and how much I wish them to come to see me. Certainly twice a year is the most I want to see them at the moment; and I would like (to see them) at least once a year. I need to write and telephone them less often than in the past; but I want to keep in touch from time to time. I feel that my parents have gained more understanding and acceptance of me through the time they spent with me and the doctors here recently, without over-burdening them. I was in a lot of pain inwardly while they were here; and through it have felt more free about my family. There were times when suicidal feelings momentarily re-occurred; but having the insight into what these were about enabled me to cope with these feelings. I think my parents showed courage, too, in facing the situation as much as was appropriate for them.

5 Social Life

My involvement in St Luther's Church and social contact there remains important to me, and I feel will continue to do so. My faith is a constructive support to me; and my friendships with people at my church (are) valuable. I should like to broaden my contact with people; but feel I can do this only gradually at my own pace after I am discharged from hospital. Joining clubs/societies is always very frightening, but may become less frightening as time goes on.

6 Being single, I am still coming to terms with my feelings that I will remain a single person, which involves pain; but I believe it is the case. I think that life can be fulfilling and rewarding as a single person. I hope that it will become easier to form friendships with others as time goes on. Relationships or friendships have always been associated with so much fear in the past; and I am not sure at the moment how much I can change this, or how gradual the change is likely to be.

7 My Obsessions

It is a relief to be able to share with others that I am obsessional, as this

has always been associated with so much guilt. My obsessions may not seem to be so terrible compared with the obsessions of others who suffer from them; yet they are to me quite crippling, and use up so much wasted energy. Anticipated anxiety especially seems to dominate my life: e.g. deciding when to have a bath, what clothes I will wear several days ahead; organising my shopping much in advance, what letters I must write and how I will express them. My mind so often is 'ticking over' with anticipated anxiety which feels destructive to my living and to the spontaneous person I would like to be. I keep all this anxiety inside and don't ever feel I can verbalise it to anyone or share it with anyone. I feel unable to release myself from this anxiety because to do so would feel as if I should cease to function as a person and disintegrate inside. Because of the extent of this fear I cannot at present envisage myself as living without these anxieties - yet I do have hope and courage to believe that gradually I might learn to live with less of it.

8 Self-Assertion and Expressing Myself

I want to practice asserting myself while I am here, but it remains at present quite frightening and threatening to do so. I don't know whether I can attend the assertion course as it is already in progress and I may not be able to join part of the way through. However, I think that the discussion and communication groups will help me in this area: and I feel positive about my occupational therapy programme as a whole, and have been quite enjoying the activities so far. I am aware of my tension constantly: but don't think this altogether takes away from my enjoyment in joining in the activities. I feel that I am getting on well with staff and other patients; but also see this as partly a defence against getting in touch with my painful feelings and (against) losing control. I have got angry on a few occasions: but there is so much rage within me which I feel has got to come out before I can be free of the pain inside. Also much terror and grief, which I have repressed again since my admission here, but remains an inner reality which I must explore during my time here. I want to learn to be freer to express my feelings spontaneously. I am sure I need to get rid of all that dreadful pain inside within this safe and caring environment - possibly through abreaction as this has been suggested. The terrifying feelings of disintegration were very real for me before my admission; and though I am aware of having cut that terror off just now, I know it exists; and I need to share it here sometime. Previously the only place where it has been safe to feel these feelings has been alone in my flat. Now I am amongst other people, I feel unsafe to feel them; and I want to find a place in which it can be safe to feel and express them with/to others.

9 Dependence and Independence

My 'romance' with pain. Because I have no sense of ever having been able to depend on my parents for emotional sustenance, I do need to have permission to be dependent here; and I seek reassurance from the staff that this will not become a lifelong dependence on finding people to lean on. As I have already stated, I want to be a free, independent person; and I won't get there without being dependent on the care here for some while - my own opinion at present is for a few months at least. I am aware that my pain has taken over my life to a large extent - like an attachment to the pain, a feeling of 'How can I live without it?' - so forming a sort of romance with it. This is something I need to deal with during my time here so that my future life need not involve this attachment. I want to be free. It is like being two different people who are poles apart. One person in me is terrified, sad, angry - feels torn apart or falling apart. The other person

is attempting to be a courageous and positive, offering, self-expressive, spontaneous individual person (who is) able to relate to other people. It is an inner battle going on between the two all the time - and whilst I wish to be the latter, I am always struggling with the former: and I defend myself against the 'falling-apart' person by striving after my whole person. To discover myself as being acceptable as less than perfect would be one step in the right direction: and I feel I'm beginning to accept myself as good enough without having to be perfect - but this, too, is going to take time. To lose my control sometimes is so important for me; so I really hope it will happen for me. It is frightening to contemplate; but I feel very positive about losing control as well, when it happens.

Table 5.11: Summary of BAI30 Assessments for Julie Allen

BAI30 Assessment on admission, discharge and end of follow-up

Item No	Section	Statement	Problem presented	Score		
				Admission	Discharge	End of follow up
1	Communication and social skills	Non verbal communication	Very tense in face, hands and leg muscles	1	3	3
2	"	Initiate conversation	Never starts conversation	2	3	4
7	"	Live with others peacefully	Withdrawal from others	3	5	5
8	"	Assertive when necessary	Unable to say 'no', behaves very politely	1	4	5
9	"	Accept success/failure	Wants always to be a 'good' girl. Anxious not to do wrong	1	2	4
10	Insight	Discuss personal feelings	Denies her real feelings	1	5	5
12	"	Identify source of negative feelings	Denies knowing the source	1	5	5
14	"	Realistic appraisal of current problems	Denies the real problem	1	2	4
15	"	Self confidence	Lacks self-confidence	1	3	5
16	"	Short/long term achievement	Has impractical expectation	1	2	5
17	"	Dealing with problems	Escape from facing her problems	1	2	5
18	"	Conventional interest in sex	Considers sex dirty	1	1	1

Item No	Section	Statement	Problem presented	Score		
				Admission	Discharge	End of follow up
27	Self and family care	Family problems	Feels rejected and not loved by her parents. Very jealous of her brother	1	2	4
29	"	Work duties	Finds it difficult to cope with decision-making	2	4	5

Researcher analysis and impression

Julie was in great pain and agony and she was desperate for professional help. She was very co-operative regarding talking about her real problems as soon as she trusted the therapeutic team.

She received a great deal of support and understanding from the staff and the patients close to her. She enjoyed this interest and care and was determined to continue keeping firm hold on it. She started a vicious circle, receiving support and love, talking about her problems and going to therapeutic sessions when she feels relaxed for a few hours, then starts to feel guilty and miserable again and needs to start receiving love and care again. She wanted to stay in hospital for 6 months in order to feel better and capable of coping with her anxiety. When the trap was broken by the consultant who directed her to face reality, she became angry, feeling rejected and losing the love and secure environment she had in hospital. To punish the hospital team she took an overdose which would not kill her but her friend would save her; however the plan did not work as she had intended. She made good use of the bridging therapy and the intensive individual therapy sessions. Within a few weeks of discharge she had dramatically improved and was able to lead a 'normal' life with very limited support. On the whole bridging therapy was very successful with Julie because she was determined to make use of it.

5.4.3 DETAILED CASE STUDY No 3 (Experimental group, Cairo fieldwork)

The following case study represents a model of the therapeutic approach that was followed in the Egyptian field work.

Personal Information and Reason for Admission (Source: Hospital Record)

The patient is called Mr Yassin El-Kholy, aged 52 years, married with 5 children (4 daughters and one son). He was admitted to El-Niel Hospital in the late summer of 1984 (September).

This was his second admission to this hospital, the first being in May 1984. On this second admission he was admitted for treatment of acute situational depression which resulted in suicidal attempts and aggression towards his family.

Presenting picture

On admission he was unconscious after trying to kill himself by taking a toxic dose of psychotropic drugs (70-tablet mixture of minor tranquilisers and anti-depressants). Yassin was kept under intensive care for four days, when he received infusion therapy, ECT and was kept under close observation. One week after Yassin had regained consciousness and gained control over his agitation, he was transferred to the open ward and was allowed to receive visitors. The researcher got in touch with the patient at this stage and his wife revealed the following information:

Development of the Problem (Source: Wife and Consultant)

Yassin worked in the Ministry of Export/Import Affairs, as head of the Wireless Department; because of the nature of his work he had to travel abroad several times to work for some years in different countries. He used to take his family with him.

Four years ago Yassin was chosen to work in Belgium for two and a half years. This was considered to be his last chance to work outside Egypt. He and his wife decided that he would go on his own and his wife would stay in Cairo to look after the children who were studying at the University.

In Belgium Yassin got emotionally involved with a Dutch married woman. His wife came to visit him during the summer holidays and became aware of this relationship. When Yassin had finished his period in Belgium, he asked the Dutch woman to go with him to Egypt and to marry him.

Once back in Egypt he began to write letters to her and to phone her quite often. The Dutch woman came to visit him in Egypt twice within six months. Yassin's wife was very upset about this but she accepted it as she was very keen to keep the family together.

Yassin had to take early retirement because he could not hold his job if he was married to a foreigner.

The second time the Dutch woman came she brought her sister and brother-in-law and they stayed in a furnished flat in Cairo for two weeks. The Dutch woman refused to marry Yassin, explaining that she could not leave her son and daughter behind; Yassin then got very aggressive, had a row and threatened the Dutch woman and her relatives with a kitchen knife. The neighbours had to interfere to rescue the Dutch people and called the police; the Dutch people left immediately.

Following this incident Yassin was admitted to El-Niel Hospital for the first time and was there for 9 weeks. After discharge he wrote to the Dutch woman to apologise and to ask her to come back. A few months later she wrote to him saying that she would never come back, she had never agreed to marry him, she was already married and had two children whom she could not leave behind.

This was another shock to Yassin, who tried to kill himself using a gun; when his

son tried to stop him, he became very aggressive, and threatened the family with a kitchen knife. Then he took 70 tablets of psychotropic drugs (40 antidepressant and 30 minor tranquilizers). His wife admitted him to hospital for the second time.

Yassin was present when the wife was revealing all these details. He did not remember the incident of trying to shoot himself or threatening his family, nor did he remember the row that took place between him and the Dutch woman, nor the letter she sent him.

Yassin later explained the situation as he saw it, without his wife being present.

He admitted that he was, and still is, deeply in love with the Dutch woman, and was very keen to marry her and he did not believe she had sent him a letter refusing to marry him. He explained that his wife had always been more interested in his money than in him, that he did not love her and had never felt happy with her. He was very sad and lost, especially that he had lost his job which he loved most. He could not accept having to lose his job and his love with nothing in return. He felt again the tendency to commit suicide, feeling unwanted, worthless and rejected by everybody.

Family Background (Source of information: wife)

Yassin's wife spoke about his childhood; he was the only son among 7 daughters and his mother and sisters used to spoil him a lot and carry out his demands immediately. Although he lost his father when he was 8 years old, his mother and sisters kept him away from any responsibility and left him free to pursue life's pleasures.

He got married when he was 21 years old and his wife was 16 years old. Being married did not stop him from being very attached to his mother. He stayed in the same house with her, spent most of his free time with her and neglected his wife, not sharing any of the family responsibilities apart from giving his wife

enough money to spend.

The wife admitted that she reacted to this behaviour by keeping him distant from the children, never asking him to look after them or take part in their care. She devoted all her time to the children and worked hard at helping them to become educated to the highest level (University level). She expressed how proud she was of her children and how happy she was to have succeeded in that aim, and that the children were her children, not his.

Social and Environmental Background (Source of information: wife and the patient)

Yassin was very outgoing, he had several relationships with other women before and after marriage. His wife used to feel hurt and wanted to stop him but she was not able to, so she had to accept the situation, pretending not to know in order to keep the children in a family setting.

Yassin also was very sociable, having contact with many friends and relatives.

Work situation (Source of information: patient)

Yassin worked as a technician in the Wireless Department of the Ministry of Export/Import. He had not been to university, but had studied for a diploma in wireless equipment. He was very good at his work and was promoted until he became the head of the department, just before taking early retirement.

Psychiatric Assessment

Yassin was diagnosed as suffering from an acute, reactive depression and personality disorder. The hospital plan of intervention used both medical and psychosocial models.

Medical care was in the form of:

- being placed in the intensive care unit to treat the toxic effect of the overdose taken by the patient

- providing the necessary physical treatment required, including infusion therapy, psychotropics and four ECT sessions
- 24 hour close observation, restricted movements, keeping within a safe environment to prevent any suicidal attempts or aggression
- daily medical checks for the first four days, then twice a week, then once a week.

Psychosocial care was carried out both formally by the psychiatric consultant and the researcher, and informally by the rest of the medical and nursing staff.

The consultant and NM assessed Yassin's condition one week after admission, using the BAI₃₀.

The following items were scored below 4:

1, 2, 4, 5, 6, 7, 8, 9, 10, 11, 12, 14, 15, 16, 17, 18, 19, 22, 24, 26, 27, 28, 29, 30.

These items were represented by the following features:

1. Avoids eye contact, low tone of voice, unclear pronunciation of words.
Does not start conversation. Keeps silent, does not participate most of the time. Resists talking about himself, gives only short answers to questions (yes, no, I don't know), is preoccupied, violent attacks towards family and hospital staff - loses control over his behaviour and refuses to accept his failure.
1, 2, 4, 5, 6, 7, 8, 9
2. Refuses to talk about his feelings or to accept that he has negative feelings. Denies negative events, denies his problems, has suicidal thoughts, lacks interest in planning for the future, deals with his problems in an aggressive manner and seeks sexual relationships outside the marital boundaries.
10, 11, 12, 14, 15, 16, 17, 18

3. Neglected his personal appearance, does not take any responsibility for preparing his own meals, uses kitchen knives to threaten his family, does not share the responsibility for household chores or look after the children; has lost his job, lost interest in socialising and in outdoor activities.

19, 22, 24, 26, 27, 28, 29, 30

Treatment Plan

The consultant and NM developed the following plan to help Yassin to deal with his problems.

1. The need for Yassin to talk about his feelings, problems, thoughts, events etc was recognised and he was encouraged to cope with the pain associated with doing this. Also he was encouraged to reveal his negative thoughts and beliefs that might contradict the social and cultural values of the Egyptian Moslem society. Acceptance, support and understanding was the basic line of therapy at this stage. The sessions were on an individual basis with NM; the consultant joined one session.
2. Marital therapy was also planned and carried out by NM both during and after the hospitalisation period.
3. Group psychotherapy was recommended at a later stage to help the patient to accept his failure and to acquaint him with the fact that others fail too.
4. Insight psychotherapy and reality-based approach were the essence of the individual therapy session.

Intervention Diary

1st session: Admission - 2nd week of September 1984

Interview: Hospital resident doctor, patient's wife and sons

Problems: YE unconscious, intoxicated with an overdose of 70 tablets of mixed antidepressants and minor tranquillisers. Suicidal attempt (tried to shoot himself). Threats to his family using a kitchen knife -very upset over a split-up with a woman whom he loved but who refused to marry him.

Intervention: Admission to intensive care unit, to deal with toxic effects of the overdose.

24 hours close observation. Restrain him in bed to prevent him committing suicide or getting violent.

Force feeding when regains consciousness.

ECT session to control his agitated behaviour and relieve his depressed mood.

Prescribe antidepressant and minor tranquillisers to help him to calm down.

Daily medical check and hourly recording of observations for first four hours.

No visitors allowed for the first week.

Evaluation: Patient unconscious first day.

Had bouts of aggression and violence, resisted being kept in bed and infusion. Disruptive behaviour was controlled by medication, ECT and restraining him in bed.

2nd session: 3rd week of September 1984

1st interview: 1st contact between patient and NM

Problems: Patient gave very short answers to the researcher's questions, refused to speak or acknowledge the presence of problems, wanted to be discharged.

Items: Assessment was done with consultant using the BAI

1, 2, 4, 5, 6, 7, 8, 9, 10, 11, 12, 14, 15, 16, 17, 18, 19, 22, 24, 25, 26, 27, 28, 29, 30

Intervention: Give the patient a brief idea about the research work, reason for interviewing him and methods of helping him. Encourage him to talk about his problems, needs and to ask any questions he has in his mind.

Evaluation: Patient denies his problems, does not trust the researcher, refuses to be a patient.

3rd session: Following day (3rd week of September 1984)

2nd interview: YE and wife with NM

Problems: Wife revealed very unhappy marital situation. Hurt and upset wife, accused him of dishonesty and oversexuality. Discussed in detail reasons for hospitalisation, suicidal attempts, violence against his son and his family, and the emotional relationship with the Dutch woman.

Items: 1, 2, 6, 7, 10, 11, 12, 16, 18, 27, 28

Intervention: Encourage the wife to talk about whatever she thinks relevant. Support the patient, do not show any signs of disrespect or disapproval of his behaviour. Ask him to comment or defend himself. Recognise the need of the wife to be able to talk; support and acknowledge her efforts.

Evaluation: The wife was very helpful in breaking the ice in starting a new relationship. She was very open about embarrassing details; needed support and acknowledgement of her pain. Yassin kept silent most of the time, tried to defend his behaviour only twice. At the beginning of the session he was very tense, smoking heavily and looking angrily at his wife. As the session went on, he began to be interested in the content of what his wife had been saying. He claimed that he cannot remember the incident of being violent towards his son or his family and that he cannot

remember the first four days of hospitalisation.

4th session: 4th week of September 1984

3rd interview: YE with NM and Dr AB

Problems: Patient does not agree with many things revealed by his wife.
He admitted his love for the Dutch woman and his unhappy marital life.
He blamed his wife as being responsible for that.
He very much regretted taking early retirement from work. He expresses feelings of unworthiness, failure and of being unwanted by anyone.

Items: 9, 14, 15, 17, 18, 19, 27

Intervention: Discussion focused on his negative feelings and thoughts.
Avoid any judgement approach and convey acceptance and understanding.
Display interest in his points of view and try to question the reasons behind the development of his family problems. Ask the patient to co-operate in the research.

Evaluation: Patient was more open about his feelings, accepted the support and understanding provided to him. Tried to defend his behaviour and marital relation. Agreed to co-operate in the research and filled in the questionnaire.

5th session: 4th week of September 1984 (same week)

4th interview: YE, his wife, 2 of his sisters, NM

Problems: Family overprotective attitude towards Yassin, ie spoon-feeding him
Difficult to hold a therapeutic session in their presence
Patient cannot talk in presence of his sisters

Intervention: Very limited discussion about his health in general and

arranged for another session.

Evaluation: Family attitude spoiled the patient's attitude and limited the therapeutic effect of the sessions.

6th session: 1st week of October 1984

5th interview: YE, his wife and NM

Problems: Wife revealed the family and social background of Yassin. Commented about his family's unhealthy influence and how his eldest sister was covering-up for his sexually unacceptable behaviour. The wife expressed feelings of bitterness and agony.

Items: 14, 16, 17, 18, 27

Intervention: Accept the wife's feelings, support her.

Evaluation: The wife cried for a lengthy period of time. Yassin tried to be supportive, kind and affectionate towards his wife.

7th session: 2nd week of October 1984

6th interview: YE with NM

Problems: Patient is still feeling depressed, sad, worthless, guilty and unable to cope with his problems. He does not believe the Dutch woman has left him for ever and wants to get in touch with her again.

Items: 7, 9, 11, 12, 14, 16, 7, 18, 27

Intervention: Discussion focused on his painful feelings, methods of coping, his feelings towards his wife and family. Design a plan to help him to develop awareness of the reality of the situation.

Evaluation: Patient cannot remember the letter sent by the Dutch woman informing him about her decision to split-up from him. Still planning to get in touch with her, he believes that she is still deeply in love with him and will come back to him. He agreed to have a "facing reality" session, ie asking his wife to bring the letter for him to read and to translate it word-by-

-word for the researcher.

- 8th session: 3rd week of October 1984
- 7th interview: YE with NM, joined later by his wife
- Problems: The same as before together with facing reality by reading and translating the Dutch woman's last letter.
- Items: 7, 9, 11, 12, 14, 16, 7, 18, 27
- Intervention: Continue the plan decided in the previous session,
ie Yassin to read and translate the letter to NM. Discuss all
the important points mentioned in the letter but he did not
believe it.
Give him time to read it several times so he can believe what
he did not believe before.
Ask his wife to join us when Yassin was ready for that.
Ask his wife to reveal again the incidents when he first received
the letter, his immediate reactions and behaviour.
- Evaluation: Yassin still disbelieved what he was reading. He accused
the Dutch woman of lying and changing her mind. He
demonstrated strong will to try and forget her and to start
planning for his future vocational life.
- 9th session: 4th week of October 1984
- 8th interview: YE with NM
- Problems: Job prospects; discharge from hospital; facing his
children, relatives, neighbours and friends after discharge. His
feelings towards his wife and her feelings towards him.
- Items: 7, 9, 14, 17, 27, 29
- Intervention: Discussion focused upon:
a) different job prospects ie governmental, private or self-
employed, his preference and needs.

- b) his fears regarding facing the outside world and how to cope with these fears.
- c) his feelings towards his wife (he does not love her); what he does not like in her; what she does not like in him; how to reach a compromise between what he wants and what she can offer.

Evaluation: Patient welcomed the idea of a self-employed job, to work as a taxi-driver with his own car.

He is still uncertain about his feelings towards his wife, has listed his dislikes in her and agreed to discuss them with her in the next session.

He received a visit from his son.

Community Follow-up

10th session: 1st week November - 1st home visit

9th interview: YE, his wife and NM at his flat

Problems: Yassin does nothing all day, shuts himself in his room for most of the day reading in the Koran and praying.

Yassin claims afraid of facing the outer world.

Negative feelings - sadness, worthlessness and a wish to die.

Admitted that he prayed to Allah to bring his beloved Dutch woman back.

Items: 8, 9, 14, 15, 16, 17, 29

Intervention: First held an individual session with the patient.

Discussion focused upon his negative feelings, his feelings towards the Dutch woman and ways of forgetting her; eg to occupy his time most of the day so he will not think of her for a long time; to visit relatives and friends; to start thinking of the practical steps for getting a job, and to start seeing the positive side of his wife to get to like her.

Asked the wife to join for the rest of the session, discuss with her how she could do things that he likes and how she wants him to change.

Evaluation: The patient was open about his feelings, admitted that he had written a letter to the Dutch woman and is waiting for a reply.

He asked his wife to dress more nicely and to use more make-up. The wife was open about sexual and marital difficulties experienced with him over the past years and how she wanted him to change. Finally, both agreed to carry out some modifications that will please the other; the wife was more flexible than the husband.

11th session: 2nd week of November

10th interview: YE, his wife and NM at his flat

Problems: Yassin is very tense, sad, anxious as he did not receive a reply from the Dutch woman.

Gets verbally aggressive towards his family; hurts his wife's feelings; isolates himself in his room.

Inadequate dietary habits (does not eat regular meals and smokes heavily).

Items: 7, 8, 9, 14, 16, 17, 18, 21, 27, 30

Intervention: Try to face problem with reality, remind him of what the woman had said and ask him to live according to God's law and conform to his will. Ask him to take an interest in his children's future and to involve himself with them.

Try to help the wife to relieve her anger; give her a chance to express her feelings of hurt and anger; help her to calm down.

Evaluation: None of previous plan was carried out either by the patient or his wife. Yassin promised to change his bad behaviour

and to start looking for work.

The wife was less angry but did not believe that he would try to change.

Insight therapy was more helpful than supportive therapy in this session.

12th session: 3rd week of November

11th interview: YE, his wife and NM at his flat

Problems: Dissatisfaction with his new job.

Still waiting to hear from the Dutch woman.

The wife is still unhappy about the way he approaches her sexually.

Items: 14, 15, 17, 18, 29

Intervention: Free discussion about the wife's feelings and complaints.

Ask Yassin to accept his wife's points of view and try to change.

Discuss with them what would be satisfactory for both of them.

Evaluation: Both Yassin and his wife were less tense about their relationships. Yassin accepted his wife's feelings and promised to approach her in the way she likes.

13th session: 1st week of December

1st phone call: YE with NM, his wife with NM

Problems: Anxious about receiving a letter from the Dutch woman.

Looking for another job.

The wife is a bit happier about the way he treats her and the children but very uncertain whether this will continue.

Items: 16, 17, 29

Intervention: To support and encourage Yassin and his wife to continue with mutually acceptable behaviour.

Evaluation: No intensive intervention is needed at this stage.

14th session: 2nd week of December

12th interview: YE, his wife with NM at his flat

Problems: Big family problem between Yassin and his wife following a phone call from the Dutch woman who rang to congratulate him on his birthday.

At first, for the sake of his wife and family, he refused to speak to her. Then he became very upset, sad, irritable and regretted not speaking to her.

The following morning the Dutch woman phoned again and this time he answered the call. This behaviour angered his wife.

Items: 14, 16, 17, 18, 27

Intervention: Allow the wife to express her angry feelings by talking about them and accept her verbal aggression towards Yassin.

Hold an individual session with Yassin and discuss the problem with him.

Discussion focused on his feelings and thoughts and his analysis of the new situation.

Evaluation: The wife became less tense after her explosion and expression of anger. She continued demonstrating signs of upset and disappointment.

Yassin was very happy with the call and started to plan to keep in touch with the Dutch woman.

Nothing the researcher could do at this stage except support the wife and increase the husband's awareness of what he may lose if he continues with this behaviour.

15th session: 3rd week of December

13th interview: YE, his wife with NM at his flat

Problems: Yassin is depressed and feels rejected after receiving a letter from the Dutch woman refusing his second proposal of marriage.

Feelings of guilt about his behaviour in the past.

Still dissatisfied at work.

Unhappy sexual relationship with his wife.

The wife feels hurt and refuses to change her sexual patterns.

Items: 9, 14, 15, 16, 17, 18, 27, 30

Intervention: Ask him to read the letter translated into Arabic and to comment on what she has written.

Discuss and analyse with him the different reasons mentioned by the Dutch woman. Researcher shows acceptance and understanding of the Dutch woman's view. Try to help Yassin to see, accept and understand the situation and be less selfish, more interested in his family, work and everyday life.

Try to convince the wife to start to change her sexual patterns and help her to understand that it is not wrong to do what her husband wishes even though it may appear odd to her.

Evaluation: Yassin is still unable to believe what the Dutch woman wrote to him, blames her for destroying his life and career.

Encourage him to apply for another job which would be more satisfactory with more pay and better promotion prospects.

The wife promised to try and carry out his sexual wishes.

16th session: 4th week of December

2nd phone call: YE with NM on the telephone

Problems: As before.

The wife began to pursue her own activities and led her own social life, visited friends and family and spent a lot of time outside the home.

Feels lonely, afraid of social life or of joining her.

Items: As before

Intervention: Discuss his fears, help him to see the positive side of

himself, try to make him feel less guilty.

Encourage him to pursue social life gradually by visiting relatives and friends who will not be critical of him.

Help him to accept people's criticism and to learn to defend himself positively.

Evaluation: Patient sees approaching social life is very difficult. Has found another job in the Red Sea area, far away from Cairo, with better payment. He is thinking of applying but afraid of being lonely.

17th session: 2nd week of January

3rd phone call: The wife with NM (YE not around)

Problems: Yassin resigned from his job.

She suspected that he was still writing to the Dutch woman. He spends most of his day reading her letters, looking at her pictures or praying and reading in the Koran.

Items: 16, 17, 27, 29, 30

Intervention: Explain to the wife that he feels disappointed by the Dutch woman's behaviour; that it is difficult to accept failure both in love and work. How his up-bringing has encouraged him to be self-centred with a large ego.

Researcher advised the wife not to neglect him completely so that he will not feel lonely; and not to pay too much attention to everything he does so that he will feel more free to pursue his own activities.

Evaluation: The wife was satisfied with the discussion and promised to be less critical of him and to try to involve him gradually in a social life.

18th session: 3rd week of January (last home visit)

14th interview: YE, his wife with NM at his flat

Problems: Yassin was depressed and felt rejected by his daughter who worked on Cairo Radio; she does not use her full name but only uses her family name (it is usual in Egypt to mention the father's name as well).

His application to work in the Red Sea was accepted and he now feels apprehensive about leaving the family and all his established life in Cairo to go and work in the desert. At the same time he wants to be on his own, away from the rejection and the negative attitude he perceives from people around him. Has to decide whether to accept or refuse the job within 48 hours.

His wife and children were happy about this work prospect, which meant more money. He interprets this attitude to mean that they do not really care about him, but want him away from them and to get hold of the money he will earn.

Items: 9, 14, 16, 17, 27, 29, 30

Intervention: Discuss with him and his wife these negative, painful feelings.

Ask Yassin's daughter to join the session.

Discuss her feelings towards her father.

Ask her to tell him during this session that she loves him, and that she will miss him if he does go to work in the Red Sea area.

Yassin was advised to get in touch with the consultant in case he needed any psychiatric help.

Evaluation: Yassin was pleased with this conversation. He received support and encouragement from his wife who said she would be waiting impatiently for his holiday of 14 days after 14 days of

work. Yassin was less apprehensive about taking this job. When he decided to take the job, this pleased the whole family.

Table 5.12: Summary of BAI₃₀ Assessments for Yassin El-KholyBAI₃₀ Assessment on admission, discharge and end of follow up

Item No	Section	Statement	Problem presented	Score		
				Admission	Discharge	End of Follow up
1	Communication and social skills	Non-verbal communication	Avoids eye contact; low tone of voice	3	5	5
2		Initiate conversation	Refuse to participate in conversation	2	5	5
4		Talks about self as appropriate	Refuse to defend himself	3	5	4
5		Responds to questions	Gives short answers	3	5	5
6		Attentive listening	Pre-occupied	3	5	5
7		Live with others peacefully	Violent, aggressive attacks	1	3	3
8		Assertive when necessary	Uses violence instead of reasoning	1	3	3
9		Accept success/failure	Unable to accept or deal with his failure	1	3	2
10		Discuss personal feelings	Refuse to talk about his problems	3	5	5
11	Insight	Awareness of negative feelings	Denies negative events or suicidal thoughts	2	4	5
12		Identify source of negative feelings	Refuses to talk about the source of his problems	2	4	5
14		Realistic appraisal of current problems	Denies being a patient or having problems	2	4	2
15		Self confidence	Lack of self confidence; feelings of unworthiness	3	3	4

Item No	Section	Statement	Problem presented	Score		
				Admission	Discharge	End of Follow up
16	Insight	Short/long term achievements	Lacks interest in pursuing positive plans for future	2	3	2
17	"	Dealing with problems	Gets overwhelmed with problems and chooses to escape	1	3	2
18	"	Interest in sex	Has sexual interests in other women, not his wife	2	3	5
19	Self & Family	Personal hygiene	Neglected his personal appearance	3	5	4
22	"	Prepare meals	Does not agree to that (cultural view)	1	3	5
24	"	Household dangers	Uses kitchen knives to threaten family	2	5	5
26	"	Responsibility for everyday needs	Shows little interest in pursuing that	1	4	4
27	"	Deals with family problems	Could not resolve or deal with the major problems	1	4	2
28	"	Seek medical help	Refuses hospitalisation and medication	1	4	4
29	"	Work duties	Took early retirement without consideration of the alternatives	3	5	3
30	"	Hobbies & activities	Lost interest in pursuing his usual pattern of activities	2	3	3

Research analysis and impression

Yassin was trapped in a vicious circle of problems. He was unable to accept the loss of love and work at the same time. He had given up his high-ranking job for the sake of his love; failing to accomplish this had meant that he had lost both his job and the woman he desired. The situation resulted in severe depression, agitation, apprehension about his future prospect and regret for his action in taking early retirement.

Socially, the situation was very embarrassing as all his friends and relatives knew about his illness and his emotional and vocational problems. Life became threatening and worthless to him. He received criticism and disapproval instead of help and support to overcome his problems.

It seemed to him that the only solution was to kill himself as there appeared to be no hope for him in this life.

Referring back to his early childhood, he was the only son among seven daughters. In Egyptian culture it is very important to have sons, which gave his mother an excuse to spoil him, never correcting his mistakes and carrying out all his wishes. This upbringing protected him from frustration which was necessary for his psychological development; his mother had raised his self esteem to an unhealthy level. He thought that he could do whatever he liked all the time without any rejection or criticism from people around him.

However, in contrast, his wife was always frustrated and disappointed by his behaviour and she had to cope with the difficulties, criticism and threats she received because she lived in the same house with her husband's mother and sisters.

To the researcher it seemed that the wife's response to all these stresses was to deprive Yassin of the pleasure of looking after the children or having any

responsibility for them. She also rejected Yassin as a person and was only interested in the money she could get from him. She devoted all her time to the children, becoming selfish with them and claimed that their success was due only to her, that her husband had nothing to do with them.

The researcher felt that the children were distant from their father and noted that it was difficult for his daughter to say "I love you, Dad" during a therapeutic session.

Most probably Yassin felt very lonely, rejected and unwanted after the death of his mother. Seeking recognition, approval, respect, acceptance and love, he found all these in the Dutch woman who did everything he wanted, even massaging his feet in hot water. She replaced his mother, of whom he was deeply fond. Transference of his feelings took place and he became completely attached to this woman and for her sake he gave up his work.

The development of the problem was very gradual and was influenced by his childhood period, youth, social and cultural rules and the political situation in Egypt at that time.

The researcher's approach to therapy was mainly insight and supportive therapy. The patient was unable to see reality, and it was painful for him to remember shameful or socially unacceptable events. The researcher persevered with the patient to help him express events; remember; face reality; accept facts; think sensibly and analyse comments on his and others' behaviour; help him to take decisions; support him through painful experiences and feelings; help him to tolerate frustration and failure; encourage him to overcome his problem; see life in a more positive way; develop an interest in other things and people; not to be overwhelmed by his problems. Different problems could be resolved by being patient and obtaining professional help where appropriate.

His wife also needed a great deal of help, support, acceptance and guidance. Some sessions were devoted to supporting the hurt wife. She found that this was her opportunity to talk about her feelings that had been bottled-up for years. Her presence at most of the sessions was very helpful as it improved and speeded up the psychodynamics of the therapeutic approach.

However, the situation continued to have its ups and downs, all through the therapeutic sessions. At the same time, the researcher sees this as a natural process associated with any attempt to dig into the past and explore hidden painful experiences covered by the client for many years.

Finally, the researcher received a letter from Yassin saying that he had got another job in Cairo. He is not happy yet, but he is coping.

5.4.4 DETAILED CASE STUDY No 4 (Experimental group, Cairo fieldwork)

This is the second detailed case study from the Egyptian field work.

Personal information (Source: hospital records and patient)

Sherifa Adely, a female patient aged 31, single, lives with her family in the family house. This was her first admission, October 1984. She is a part-time student in the Faculty of Commerce, Cairo University, and works full-time as a secretary for a large housing agency.

Presenting picture (Source: hospital record and patient)

Very depressed, very weepy, suicidal thoughts, had unsuccessfully tried to take toxic drugs. She came to hospital with a friend and had asked for voluntary admission. She was kept under close observation on a closed ward. She did not inform her family about her admission and refused to let the hospital staff tell them; but asked her female friend to visit her family to tell them that she had been admitted to a medical hospital with a kidney complaint and that she was not allowed to receive visitors at the moment.

For the first two days in hospital she was continuously weepy, needed sleeping tablets at night and for the first day refused to eat.

The researcher contacted her on the second day after admission.

Development of the problem (Source: patient)

Sherifa is a part-time student in the Faculty of Commerce, in the third grade. She was also working to support the family. Her father had become hemiplegic when she was 14 years of age. Being the eldest child, she had to leave school and work to help her mother and younger sisters and brothers.

At the same time she was studying at home until she managed to be successful in

joining the University on a part-time basis.

According to the patient, she was very successful and had managed to pass her exams each year, although this year she had failed her exams for the first time; to save herself embarrassment she told her family that she had passed. Although at first this painful experience appeared to be her real problem, following sessions revealed the real cause of her depression.

She was in love with one of her colleagues in the faculty, who had officially proposed to her family, but they did not accept him at first because he was still a student with not enough money to begin married life. Eventually they agreed because she was so insistent. However, the engagement lasted only six weeks and then was broken off because of pressure from Sherifa's family for them to be married as soon as possible. In Egyptian society it is the custom for the groom to buy an expensive gold present for his bride, to pay a certain amount of money to help with buying the furniture and with renting a flat - which is a very expensive matter in Cairo. (The family revealed later that they had to do this because he began to spend a lot of time with her at their house and they considered this inappropriate and embarrassing.)

Sherifa admitted that she could not keep away from him even after the engagement was broken off. One day Sherifa and her ex-fiancee decided to get married without her family knowing so that he would not have to pay a lot of money to her family. They did get married and spent the days together in hotels and then she went back to the family house to spend the nights there, so that nobody would know. They were very happy for two weeks then he divorced her as a result of orders from his family (so he told her). He did not give her any of her financial rights nor pay her back the money which he had borrowed from her.

To Sherifa this was a dreadful experience, she lost everything and had gained nothing; she became a divorced woman, without her family's knowledge and she

had lost her virginity, which is a great shame in Egypt. The trauma was too much to cope with and she tried to take a toxic overdose of drugs but her friend stopped her and brought her to the hospital.

Family background (Source: patient and elder half-brother)

Sherifa is the eldest daughter of the family and has two younger brothers, two younger sisters and one elder half-brother. She comes from a poor family and she had to find work at the age of 14. Her mother also had to work at a 'very degrading' job as a rubbish collector.

Her mother has always been rough and rigid as she preferred sons to daughters and has helped one son to get married and to enjoy a settled life. Sherifa's two brothers work and did not continue with higher education. One of her sisters is also married and the other is in the third year of secondary school studying for the equivalent of 'A' levels in Britain. Sherifa complained that her mother is a nervous person who gets angry very quickly, lacks understanding of Sherifa's feelings (when she wanted to get married her mother did not show any degree of sympathy), swore a lot and did not show any respect for her (she would insult her in front of others, even her fiancé). She also hit her on a few occasions. She treated Sherifa's fiancé badly, never welcomed him and considered him to be unsuitable because he did not have enough money to start married life and that by marriage the family would be deprived of Sherifa's monthly payments. Her father was a very weak person who did not oppose any decision taken by his wife; similarly Sherifa's brothers liked to please their mother so that they could enjoy a peaceful life and not arouse her anger.

The patient explained that her half-brother is much older than her, married and keeps away from family problems but he had been very supportive to her and within the family she loved him the most.

Social and Environmental Background

Sherifa is a sociable person with a number of female friends. She spends some of her spare time with her friends, and she likes to dress well and to use make-up. She is free to make social visits with her mother's consent.

She claimed that her life had previously been all work and study and she had never had an emotional experience before this occasion.

Work situation (Source: patient and personal observation)

Sherifa has worked since she was 14 years old; at first she worked in private firms for very low pay but later she got a job with a large state housing agent and is now paid reasonably well in accordance with her grade and qualifications. However her payment is considered insufficient for everyday life needs.

At the same time she is studying at the University. Although university education in Egypt is free, she still spends a lot of money on books and photocopying lecture material. She considered herself to be very successful both at work and with her studies. This year was the only occasion when she had not passed her exams due to her family and emotional problems.

Psychiatric Assessment

Sherifa was diagnosed severe reactive situational depression. The hospital plan of intervention used the psychosocial model with the help of the medical model.

The medical care was in the form of:

- close observation for fear of suicidal attempts
- provision of sleeping tablets at night
- placed on course of anti-depressant drugs and minor tranquilizers.

The psycho-social care was carried out mainly by the researcher with the help of

the psychiatric consultant (Dr AB). The assessment was carried out by the consultant and the researcher.

BAI Assessment Score on Admission (see overleaf).

Treatment Plan

The consultant and NM developed the following plan to help Sherifa to deal with her problems:

1. Provide a safe, secure environment for Sherifa to encourage her to talk about her problems without hesitation or fear.

It was decided to provide this on an individual basis with NM alone so that Sherifa would not be embarrassed to talk about her personal problems or shameful experiences.

2. Encourage Sherifa to agree that her family should be informed of the situation.
3. Try to meet the family to find out their attitude in general on similar problems and to explain Sherifa's problem and try to gain their support.
4. Arrange for Sherifa to meet her family, would find support and help as needed.
5. Supportive analytical approach of psychotherapy is to be used during the individual therapy sessions.
6. Encourage Sherifa to be more assertive and make her aware of the difficulties she experienced due to her lack of assertiveness.
7. Plan with her the acceptable, practical course of action to begin to face reality.
8. Long-term plan for follow-up and post-discharge care to be arranged.

Intervention Diary

Admission: 2nd week of October 1984

1st interview: Hospital resident doctor, patient and her friend

Problems: SA very depressed and weepy, suicidal tendency and family problems

Intervention: Informal admission, to closed ward, under close observation.
Anti depressants, minor tranquilizers and sleeping tablets at night
No visitors for the first week

Evaluation and outcomes: Patient continued to be weepy, refused to eat, withdrawn, very limited conversation with hospital staff and patients

1st session: Following day of admission, 2nd week of October 1984

2nd interview: First contact between SA and NM

Problems: SA very depressed and weepy. Explained some problems:

1. Her relationship with her mother is not very good, is not accepted or respected. Her mother prefers her sons to her daughter, although she is the eldest and the one who supported the family financially for many years.
2. Her father's illness and weak personality
3. Failed to pass her final exams for the first time in her life
4. Could not face anybody with her failure, so hid them and told people that she had passed.
5. The beginning of the new term (1st week of October) - she could not go to college or see all her friends who had passed to the 4th year and she is the only one left behind.

Items: Were left to be identified in the following session

Intervention: Listen to the patient
Accept her feelings and allow her to cry during the interview

Acknowledge her efforts to support the family

Encourage her to accept this year's academic failure

Accept her suffering and support her during the session

Discuss with her the problem of informing her family about not passing her exams and their reaction and how she should deal with this.

Evaluation and outcomes: Both SA and NM agreed to postpone informing the family at that stage. Patient was still weepy and unable to control her emotions. Agreed to have some soup and to start eating small, light meals.

2nd session: 3rd day after admission, 2nd week of October 1984.

3rd interview: SA with consultant and NM

Problems: As before and is broken-hearted because her engagement has ended. She loves her fiance but her family do not agree.

Items: 8, 9, 10, 15, 16, 17, 21, 27, 30

Intervention: The consultant made detailed case notes

Explained to SA the kind of help the hospital could offer (including services of NM)

Asked her to co-operate in the research project

Gave her the questionnaire forms to fill in

Continued with the assessment process

Evaluation: Patient agreed to participate in the research project

Agreed with the plan of care which was explained to her

Promised not to commit suicide

Became less weepy.

3rd session: 4th day after admission, 2nd week of October 1984.

4th interview: SA with NM

Problems: As before together with the real cause of her depression. SA revealed

the whole story of her love, marriage and divorce.

Feeling very bitter and ashamed of what she has done (getting married without her family's knowledge, practising sex with her ex-husband and losing her virginity).

Items: As before.

Intervention: Support the patient whilst expressing her feelings
Avoid any judgemental attitude towards her
Reassure her that what she has done is not religiously offensive
Encourage her to face all her feelings and thoughts and to be open about it all
Show sympathy and affection towards her painful experiences
Try to help her to become aware of the circumstances that led her to behave as she did and thus not blame herself so severely.
Explain to her that she can keep her marital rights even though her ex-husband had tried to deprive her of them. (There is a special allowance which the ex-husband should pay for one year if he divorces his wife.)

Evaluation: The patient was very open about all the details, even the shameful and embarrassing ones. She expressed her painful feelings and was very spontaneous.
She explained that she felt better after talking, but was still feeling depressed, shocked, bitter and apprehensive about facing the outside world including her family and colleagues at work.

4th session: One week after admission, 3rd week of October 1984.

5th interview: SA with consultant and NM.

Problems: As before, together with a visit from her friend to inform her that her family are very worried about her and they want to visit her.

Items: As before.

Intervention: Discussion focused upon planning a strategy to have the family visiting her without causing a lot of disturbance to her plan of therapy.

More details about the patient's family reactions, attitude, behaviour were taken from the patient

The consultant asked the friend to inform the family of the hospital name and address and ask that only one person should come on the first visit.

Patient discussed in detail how she is going to meet them and what she is going to say.

The plan was to formally interview the first family member who comes to see SA. Inform him that she is very depressed and has suicidal tendencies and that she is under close observation and that part of her sadness is due to the fact that she did not pass her exams.

5th session: Same day, in the afternoon, 3rd week of October 1984.

6th interview: SA's youngest brother with NM.

Problems: Family apprehension about SA's condition.

Youngest brother came unexpectedly.

SA reluctant to see him.

Items: 8, 9, 15, 27

Intervention: Work out the plan previously mentioned

Allow him to meet his sister briefly with NM present

Ask him to reassure the family and convey to them the information he had just learned.

Evaluation: SA was less apprehensive after meeting her youngest brother, who was genuinely interested to know how she is and that she is safe (not crazy). He promised to be supportive to his sister as much as possible but he explained that he works in the military

services and does not have much time to spend with her at home.

6th session: Following day, in the morning, 3rd week of October 1984.

7th interview: SA's eldest (half) brother and younger brother, SA, the consultant and NM.

Problems: Informing SA's brother of the whole situation.

Items: 8, 9, 10, 15, 16, 17, 27, 30

Intervention: Again, very gradual, allow her brothers to express their worries and need to know the real problem. Discuss with them their mother's attitude and the pressures suffered by SA

Remind them of SA's sincere help to the family, particularly in financial terms

Make them aware of her suffering in the family home, also the pain she experienced by not being married when all of them are happily married and settled, and make them acknowledge her sacrifices

Discuss with them their behaviour and attitude toward her ex-fiancé. Explain to them the undesirable effect of such a negative attitude and behaviour.

Inform them how she was deeply in love with him and she could not find any sympathy nor guiding advice

Inform them that she had got married and divorced within two weeks

Ask them to be understanding and supportive, and to protect her from her mother's anger

(Make them aware of her suicidal tendency).

This was explained to them without the presence of SA .

Evaluation: The gradual preparation for informing them of the problem was very successful. They showed sympathy and care for SA. They explained that SA is naive, did not have any relationship

at all before, which is why she was fooled by that person.
 They promised to protect her against her mother's anger.
 They asked her to try to forget about her ex-husband, and to concentrate upon her studies and be open with them about anything that might bother her in the future.
 They asked her to let them know if her ex-husband tries to get in touch with her and they agreed to meet him if he asked to do so.
 The brothers' attitude was very impressive and resolved many of the problems.
 SA was relieved and satisfied at the end of the meeting.

7th session 2 days later, 3rd week of October 1984.

8th interview: SA with NM.

Problems: SA explained that she is still in love with her ex-husband.
 She can forgive him for all that he had done providing they can get married again.
 She had received some news from one of her friends that he had started going out with another girl. This made her very jealous.

Items: 8, 15, 16, 17

Intervention: Discussion focused on the details of their relationship.
 Make her aware of what he has done to her; he was after pleasure and her money
 Accept her feelings and encourage her to suppress them
 Discourage her from seeing him or getting in touch with him without her family's knowledge, especially her eldest half-brother.
 Encourage her to think of her future and her studies and to work hard to get her BSc.

Evaluation: SA agreed with the advice but found it very difficult to cope with.

SA decided to stay in hospital until the end of the week.

Follow-up arrangements took place.

8th session: 3rd week of October 1984.

9th interview: SA with the consultant and NM.

Problems: SA is depressed and weepy again because her ex-husband came to visit her in hospital and she refused to meet him and afterwards regretted her earlier decision and realised that she wants to see him again.

She felt great conflict between listening to the therapist's advice not to see him and her strong desire to see him.

Intervention: Discussion focused on:

1. Her strong feelings towards her ex-husband
2. His feelings towards her
3. Her family situation
4. The outcomes of seeing him
5. Her future plans
6. Strategy for facing her problems.

Items: 8, 9, 15, 17

Evaluation: SA realised the importance of becoming assertive with him and agreed to control her feelings and to start planning for her future hospital discharge.

SA became less weepy.

Community follow-up:

9th session: 1st week of November 1984.

10th interview: SA, her ex-husband with the consultant and NM at the hospital.

SA and her ex-husband visit the consultant and NM at the hospital to discuss their marital problem.

Problems: SA does not feel secure with her ex-husband; she does not trust him and cannot believe what he says, but she is still in love with him and wants to have an official engagement. He claimed that he was still in love with her and he wants to remarry her after graduation. He asked not to be pressurised at the moment because he has no money and cannot afford an official engagement.

Items: 7, 8, 9, 15, 16, 17, 18, 27, 29, 30

Intervention: Discussion focused on finding a happy medium which could help them to realise their conflict and to encourage SA to decide whether she is going to wait for him or whether she will stop seeing him.

Evaluation: Both SA and her ex-husband agreed to meet only in the University and to stop pressurising each other. SA decided to wait for him to qualify, so she can also concentrate on her studies.

10th session: 3rd week of November 1984.

11th interview: SA with NM at her work.

Problems: SA met her ex-husband, he was very kind and supportive to her. Tried to persuade her to meet him in hotels without marital boundaries and threatened not to see her again if she did not agree. At home she was under great pressure from her mother. The mother was very angry with her, kept calling her bad names. Informed everybody (neighbours, friends and relatives) of what Sherifa had done. SA was very upset about her mother's behaviour. Again SA was under great pressure.

Items: As before.

- Intervention:** The researcher explained to SA the negative results both from the religious and cultural point of view if she meets her ex-husband.
- The researcher was very hard with SA and encouraged her to restore her self-dignity.
- (In Egypt it is very shameful to practise sex without marriage, usually men do not marry the girl who has had sex).
- Encourage her to be patient with her mother.
- Evaluation:** SA agreed with the discussion and promised not to see him in a hotel.
- Explained that she will meet him to let him know about her decision.
- She realised that she was behaving very weakly and decided to set limits to her weak behaviour and promised to become stronger.
- 11th session:** 2nd week of December 1984.
- 12th interview:** NM with SA at her place of work.
- Problems:** Her mother still treating her very badly.
- Her colleagues at work do not know about the marriage incident and problem and so still call her Miss S.
- Her best friend, who knew all about the incidents, has behaved in a very bad way towards her after a row over some money SA had lent her. Her best friend informed all her colleagues at the college that SA was in a mental hospital and that she is crazy and does not know what she is doing or saying.
- Her ex-husband was very cross with her when she met him and refused to go with him to a hotel.
- He threatened to visit her work and inform her colleagues what had happened between them.

SA was very upset and shocked about everybody's behaviour towards her.

She could not go to college and was worried about the lectures she had missed during the previous weeks (term started at the beginning of October).

Items: As before.

Intervention: Discussion focused on:

1. Her feelings of disappointment and worry
2. Her expectation from her friends at college and her colleagues regarding what they know or will find out
3. Planning an easy way of informing her colleagues at work that she got married, not to mention the divorce but after a few weeks she could inform them about the incident of the divorce.
4. Encourage her to continue being strong and assertive with her ex-husband. She decided to sue him in Court to get her financial rights and to break his heart, as he had done to her. Also she thought that suing him in Court would prove to everybody that she was his victim.

Evaluation: The researcher accepted SA's decisions about resolving her problems.

Advised her to be very careful about what she says in Court and asked her to get a legal adviser.

SA was behaving in a strong confident way; agreed to announce to her colleagues at work that she had got married and agreed to start going to her college and face her friends.

12th session: 4th week of December 1984.

13th interview: NM with SA at her work.

Problems: SA went to a lawyer and got legal advice, went to the police

and presented the case.

Her ex-husband does not know about it, but had asked her to meet him and explained his worries that she might sue him in Court. He tried to find out from her whether she had taken legal action but she refused to say.

He requested to meet her family but they refused to meet him.

Her mother is less aggressive towards her but she still gets at her from time to time.

Items: 7, 27, 30

Intervention: Advise her to keep to the same plan.

Evaluation: Does not tell him any information about her or what she has done.

SA was happy with her achievement and that he is now terrified of her and her colleagues at college accepted her amongst them as usual.

She attends lectures regularly.

13th session: 2nd week of January 1985.

14th interview: SA with NM at her house.

Problems: Her ex-husband is threatening her to reconcile* the divorce and remarry her if she does not stop the legal action against him.

SA felt very weak, apprehensive and did not know what to do.

She was afraid that he might reconcile the marriage and refuse to give her any rights.

Items: As before.

* In Islamic religion, the divorced couple have a 3 months period for reconciliation, during which time the husband can claim the marriage should continue on the same basis as it was on before. No marriage ceremony or arrangements are needed in this case.

Intervention:	<p>Discussion focused on:</p> <ol style="list-style-type: none"> 1. How he can harm her. 2. Plan what she can do to avoid that problem . 3. Try to reassure her and to calm her down .
Evaluation:	<p>SA continued to be worried about the whole situation.</p> <p>Agreed the plan to meet him and reassure him that she will withdraw the case from court.</p> <p>To go easy with him for the next two days, ie to the end of the reconciliation period.</p>
14th session:	3rd week of January 1985.
15th interview:	SA with NM over the telephone .
Problems:	<p>SA's husband reconciled the divorce and they became husband and wife again.</p> <p>She has mixed feelings, happy to have him back but worried about the future.</p> <p>Her family become very angry with him and her and threatened to throw her out of the family house.</p> <p>Feels angry with her family's behaviour .</p>
Items:	27
Intervention:	<p>Encourage her to be assertive with her family and to threaten them that she will not give them money</p> <p>Advise her to be cautious when dealing with her husband and not to trust him completely</p> <p>Encourage her to study hard so she can finish her studies quickly.</p>
Evaluation:	SA less apprehensive, accepted the situation, agreed to be assertive with her mother.
15th session:	1sts week of February 1985 .

16th interview: SA with NM at her house .

Problems: As before.

Items: As before .

Intervention: Discussion focused on the practical steps for a future plan:

1. Treat her husband well as he is being kind to her .
2. Continue being assertive with her mother .
3. Save some money so they can rent a flat as soon as her husband qualifies .
4. Concentrate on her studies so that she can pass .

Evaluation: SA realised that her marital and family problem will not be solved for some time, until she and her husband become qualified and independent, which means a wait of another 6-8 months.

She agreed to be patient and work hard at her studies and encourage her husband to do so.

However, she was still not feeling happy about the difficulties she has to face.

Termination of the follow-up took place.

Table 5.13: Summary of BAI30 Assessments for Sherifa Adely

BAI30 Assessment on admission, discharge and end of follow-up

Item No	Section	Statement	Problem presented	Score		
				Admission	Disch	End of follow-up
7	Communication and social skills	Live with others on peaceful terms	Accept living in miserable atmosphere	3	3	4
8	"	Assertive when necessary	Allow others to take advantage over her	2	4	5
9	"	Accept success or failure	Unable to cope with experience of failure	1	3	5
10	Insight	Discuss personal feelings	Hesitant to be open about her real problems	2	4	5
15	"	Self-confidence	Lost her self-confidence	1	3	5
16	"	Short/long term achievement	Lost interest in planning and in life in general	1	4	4
17	"	Dealing with problems	Unable to act on solving her problems	1	4	4
18	"	Interest in sex	Accepted marriage without her family's knowledge	3	3	5
21	Self and family care	Eating habits	Refused to eat on admission	2	5	5
27	"	Dealing with family problems	Unable to face her family	1	3	4
29	"	Work situation	Unable to concentrate on her studies	1	3	5
30	"	Hobbies and activities	Limited to few social visits	3	3	3

Researcher analysis and impression

Sherifa's problem started with psychiatric manifestation in the form of depression, suicidal tendency and emotional distress.

However, during the course of treatment it turned to the family and marital problems and by the end of the course of treatment it became social/marital problems. Sherifa was the only one in her family who managed to join the university. She enjoyed the respect and attention from all her family members, especially because of the financial help she was offering. Considering she had reached the age of thirty-one without getting married or having a chance to be involved in emotional experience was troubling her.

Her younger brother and sister got married while she had a chance to continue work, study and earn money to support the family. Unfortunately all her problems started as soon as she had an emotional relationship. The person whom she loved was a student from a poor family who did not have enough money to begin married life.

Her family and especially her mother did not like this choice but they could not argue too much at the beginning; later, when they found that he could not afford any form of independent living, they rejected him in a rough way.

SA did not receive objective advice or a loving attitude from her family; at the same time she felt that this was her first and last chance to get married, considering her age.

Her life became complicated by divorce and loss of respect or even welcome by her family and especially her mother.

The situation might have been less complicated if the state government helped to resolve such problems. But in Egypt this is not the case. Sherifa's problem

became multi-dimensionally complicated; emotionally and psychologically very distressed, socially threatened, financially broke and educationally failed to pass her exams. The psychological intervention given to Sherifa and her family was useful in decreasing the pain and helping her work at resolving her problems.

However, she was to suffer ill-treatment from her mother for many more months until she could find somewhere to live with her husband.

The social and material support for this case was essential but unfortunately inaccessible.

CHAPTER 6: DISCUSSION

- 6.1 Introduction
- 6.2 Limitations of the Study
 - 6.2.1 Practicality of Bridging Therapy
 - 6.2.2 Complexity of Design
 - 6.2.3 Limited Statistical Significance
 - 6.2.4 Use of a New Behavioural Instrument
 - 6.2.5 Unobtrusive Measures, Data Redundancy and Observer Time
 - 6.2.6 Cross-Cultural Differences
- 6.3 Assessment of Therapeutic Effectiveness of Bridging Therapy
 - 6.3.1 Bridging Therapy as Evaluation Research
 - 6.3.2 Bridging Therapy in its Cross-Cultural Context
 - 6.3.3 Bridging Therapy as a Model for Comprehensive Community Psychiatric Nursing Care
- 6.4 Discussion of Results
 - 6.4.1 Discussion of Quantitative Data
 - 6.4.1.1 Comparability of BAI(30) with GHQ Scores
 - 6.4.1.2 Lack of Statistical Differences Between Experimental and Control Groups
 - 6.4.1.3 Lack of Statistical Difference Between Discharge and Post-Follow-Up Scores
 - 6.4.2 Discussion of Qualitative Data
 - 6.4.2.1 Patients' Perceptions of Their Problems
 - 6.4.2.2 The Therapeutic Intervention Model
- 6.5 Implications of the Study
 - 6.5.1 Clinical Implications
 - 6.5.2 Educational Implications
 - 6.5.3 Organisational Implications
 - 6.5.4 Research Implications
- 6.6 Conclusion

CHAPTER 6: DISCUSSION

6.1 Introduction

In this chapter, various aspects of the effectiveness, or otherwise, of bridging therapy in providing an innovative model of nursing care for mentally ill patients are discussed. The discussion focuses on both negative and positive elements of the study. These issues include the limitations of the study; assessment of the therapeutic effectiveness of bridging therapy; discussion of the results obtained, both in quantitative and in qualitative terms; and finally, on the various implications and conclusions to be drawn from the study.

It is hoped that this analytic discussion may shed further light, both on the difficulties encountered during the development and implementation of this research; and on the innovative strategies employed for purposes of the study. Additionally, both the Flexible Integrative Approach (FIA) as a model for therapeutic intervention, and the Behavioural Adjustment Inventory (BAI₃₀) are examined. Briefly bridging therapy was an attempt to develop a new model of hospital- and community-based psychiatric nursing care that would integrate the use of both hospital and community facilities. In this sense, bridging therapy adopted the concept of maximum continuity of nursing therapy as a potentially favourable means of patient care.

The philosophy underlying bridging therapy is not a new one. As early as 1964, Ministry of Health circulars were stressing that special emphasis should be placed on the need for collaboration between mental hospitals and local health authorities, general practitioners and voluntary agencies, in the development and expansion of rehabilitation and after-care services.

The 1964 memorandum, addressed specifically to hospitals for the mentally ill, stressed that the mental hospital should no longer be considered merely as a centre for the treatment of in-patients; but as part of a comprehensive service, with in-patient care as only one of its many components (May, 1968).

Despite the fact that mental hospitals were seen as part of the Mental Health Service, community services were still largely perceived as an "either-or" alternative to hospital care (Hill, 1968). Bridging therapy, therefore, was an attempt to put into effect the long-established principle of an integrated service, specifically in the area of integrated psychiatric nursing care; hopefully with the effect of reducing in the experimental group the tendency for repeated admission, which was estimated in 1975 at 64 per cent of hospitalised patients (Maisey, 1975)

With regard to conditions in Cairo, it has already been stressed that the Egyptian Mental Health Service is mainly centred on hospital care, either as in-patient or out-patient. There is no system whereby nurses visit patients or their families in their own homes, or provide any form of assessment or follow-up service. Social workers are usually concerned only with financial welfare aspects of help for patients and their families. Nevertheless, the levels of financial support available are very poor in relation to living costs and in comparison with British standards.

Patients with neurotic illnesses or mild psychoses are treated on an out-patient basis, their symptoms being controlled by the use of major or minor tranquillisers, antidepressants or ECT. Private practices accept the admission of these cases for in-patient treatment and also group and individual psychotherapy is practised in private clinics. Therefore the

bridging therapy study took place in a private hospital where patients with neurotic and mild psychotic problems could receive in-patient treatment. Although the concept of bridging therapy was new to the Egyptian community, yet the same would apply to any new theory related to community psychiatric nursing care, because of the absence of this system in Egypt.

Generally speaking, nursing care in Egyptian mental hospitals is still confined to the custodial model. Patient follow-up is undertaken by the psychiatrist, whose main concern is to control the patient's pathological behaviour by means of chemotherapy. This was very much the situation in the El-Niel Hospital where the study took place. However, it is important to mention that the medical team there have expressed their awareness of this problem; but regard any change as very difficult due to shortage of time, money and qualified nursing and other staff.

6.2 Limitations of the Study

Limitations of the current study may be described under six main headings. These include:

- 1 Practicality of bridging therapy as a model for comprehensive psychiatric nursing care.
- 2 Complexity of design produced by "methodological mix" approaches.
- 3 Lack of statistical significance resulting from quantitative data analysis.
- 4 Use of a new behavioural instrument (the BAI) prior to completion of its full validation.
- 5 Use of unobtrusive measures as a factor in cost-effectiveness of the study.
- 6 Difficulty of prediction due to cross-cultural differences between

the Sheffield and Cairo settings.

Each of these issues will now be discussed in some detail.

6.2.1 Practicality of Bridging Therapy:

In Chapter One, three hypotheses were identified as forming the basis of this study. They focused on:

- (i) the supposedly better nursing care to be provided through bridging therapy than by means of standard care both in Sheffield and Cairo;
- (ii) the supposedly more sensitive measures of patient outcomes to be achieved by a combination of psychometric and unobtrusive measures;
- (iii) the feasibility of cross-cultural implementation of bridging therapy.

It was hoped that this study would constitute a successful attempt to support each of these hypotheses. However, both during and after the completion of the work, it became clear that none of these hypotheses could be fully supported.

With regard to the first hypothesis, it became clear that the comprehensive nursing service intended by bridging therapy was very difficult to establish with any precision, due to numerous constraints including finance; adequacy of training of health workers; transport; attitudes to mental illness; workforce and time available: and, most importantly, the appropriateness or otherwise of the service provided to suit differing patient needs. In this sense, the first hypothesis was only partially supported, since, although significant improvements occurred in the condition of patients receiving bridging therapy, these also occurred in patients receiving conventional psychiatric nursing care. Thus comparison between these two groups of patients did not demonstrate the superiority of bridging therapy over

more conventional methods. Further discussion of this finding will be found later in this chapter (6.4.1, Discussion of the Quantitative Data).

With regard to the second hypothesis, the psychometric instruments used included the GHQ, EPI and BAI₃₀. Patient outcomes were measured using these instruments to demonstrate in quantitative terms the effectiveness of bridging therapy and the FIA as an eclectic therapeutic mode of intervention. However, these psychometric measures could only deal with certain aspects of a patient's performance, whether observable or self-reported. Other dimensions of patient behaviour could only be comprehended within their context of occurrence; and through an understanding of the dynamics of the various relationships existing between the patient and members of his social "circuit". Therefore the qualitative assessment of patients' behaviour was an extremely important factor in the present study. In general terms this hypothesis was supported.

The third hypothesis was expected to face a number of serious difficulties which were possibly not capable of resolution. Nevertheless, cross-cultural implementation was considered as a very important aspect of bridging therapy. Therefore an important part of the study involved its attempted implementation in the two differing cultural contexts represented by Sheffield and Cairo. Surprisingly, the expected cross-cultural barriers and problems did not prove as troublesome as at first anticipated. In Sheffield, this was probably at least partially due to the role undertaken by the researcher as an additional member of nursing staff for a period of six months. This helped the process of familiarisation, both for patients and researcher. Conversely, in Cairo the researcher shared the cultural background of the patients and staff; and was able to introduce the concept of bridging therapy to both in culturally acceptable ways.

The real difficulty encountered with this third hypothesis was that of achieving strict comparability of the various cross-cultural findings; due largely to the advent of certain potentially confounding variables which were difficult to control. For example, a major factor influencing the course of bridging therapy in Sheffield was the tendency of other members of the therapeutic team to encourage patients' independence and adherence to their keyworker. By contrast, in Cairo the attitude of families towards their ill member was in many cases too protective, and he would be treated almost as a child. Despite this and similar problems, bridging therapy was implemented with reasonable effect in both cultural settings; and produced significant comparable results. Thus the third hypothesis was also upheld.

6.2.2 Complexity of Design

As previously noted in Chapter Four, the complex nature of this inquiry necessitated adoption of the "methodological mix" (qualitative-quantitative) research approach. Therefore its design included features both of quasi-experimental and of action research methods. Despite the appropriateness of this particular design in investigating both the theory and practice of bridging therapy, a number of associated limitations were unavoidable. These included the following considerations:

- (i) As is frequently the case whenever psychometric "before-after" measures are used, the pre/post-test effects of the quasi-experiment were mainly to be measured in statistical terms. This procedure necessarily leaves out of account other, potentially important factors, such as various changes in the patients' circumstances, that could materially influence their recovery. Therefore for the uncautious, any scored progress is likely to be attributed to the effects of bridging therapy rather than to unmeasured alternative factors.

- (ii) The data collection phases occupied three-quarters of the time allocated to the entire study. During this time it is reasonable to hypothesise that both researcher and informants experienced maturation effects. Thus during the study, patients had much time in which to acquire additional skills in answering questionnaires; develop further insight into their problems; and become more familiar with the requirements of the therapeutic intervention. For her part, the researcher gained more experience in handling difficult situations and establishing successful rapport with the patients. Therefore, scoring could be influenced, either directly or indirectly, by these maturational effects.
- (iii) Together with quasi-experimental design, the technique of purposive sampling was used in this study. Unfortunately, some degree of selection bias and lack of representativeness are inherent features of this method. Consequently, causal inference and generalization must be treated with caution when dealing with these data.
- (iv) There are possibilities of observer error both on the part of the researcher and of the other raters. Although the action research approach emphasises the participation of a team of raters in order to reduce the subjectivity of individual assessment, yet observer error can still occur. This may, in some cases, be due to the differing cultural and educational backgrounds of the various raters. Yet another important variable may be an attempt on the part of patients themselves to present differently certain aspects of their problems to different members of the therapeutic team.
- (v) Statistical regression due to unreliability of measurement may

occur. Periodic testing of the BAI for inter-rater reliability achieved levels of 50-75 per cent in Sheffield and 75-100 per cent in Cairo. Although these may be accepted as respectable levels of inter-rater reliability, yet, ideally, higher consistent levels should be aimed at. By comparison, the PSE (Wing et al, 1967) achieved 95 per cent inter-rater reliability for most of its items. It is clear that the scores on the BAI suffered some statistical regression on occasions where disagreement between raters occurred.

- (vi) Some differences may be expected to occur as a result of variations within each patient's pre-experimental history. Thus at the outset of the quasi-experiment, factors such as patients' history, background and experience were not included in the general criteria of selection. However, great care was devoted during the matching process, to ensure correct matching of patients in control and experimental groups in respect of salient features of their background experience, illness and therapeutic histories.
- (vii) Delivery of bridging therapy to the experimental group led to interaction of a number of confounding variables. For example, in Sheffield the consultant's support for its underlying theory of continuity of care encouraged other members of the nursing team on Ward 56 to develop a post-discharge group and associated "drop-in" policy; which resulted in control patients, ostensibly receiving only the conventional type of care, being given useful continuous support following discharge. Similarly, in Cairo, junior psychiatrists began encouraging their patients to keep in touch, and to attend some hospital-based group therapy sessions even after their discharge.

- (viii) "Hawthorne" effects regarding the study occurred in both settings.

Bridging therapy adopted an overtly experimental approach both for ethical and for therapeutic reasons. However, this approach was not attractive to the Sheffield-based sample; and some expressed their anxiety about functioning as "guinea-pigs" for purposes of the study. Conversely, in the Cairo context, patients tended to regard their participation in the study as a generous favour accorded to the researcher; and several tried to demonstrate how knowledgeable they were about various different aspects of their problems.

6.2.3 Limited Statistical Significance

A lack of statistically significant differences was noted at two levels of assessment:

- (i) between discharge/post-discharge recovery scores in both study contexts:
- (ii) between experimental and control groups at all three assessments in both study contexts.

The negative findings in (i) would lead to the conclusion that, in both contexts, the follow-up phase of bridging therapy did not help patients achieve further significant progress apart from that already achieved in hospital. There are, however, two reasons why this conclusion should be viewed with caution:

(A) Measurement "Ceiling" using the BAI₃₀

In practice it became obvious that the 1 to 5 scaling on the BAI₃₀ Recovery Index produced a "ceiling effect" by allowing an interval of no more than one point for scoring patients' post-discharge

recovery status in many cases. Thus patients scoring 4 on discharge will not be able to score more than 5 when they demonstrate full recovery. Such a slender numerical difference will be difficult to demonstrate statistically.

(B) Difficulty in Isolating Variables

Evaluation research using patient outcome measures as an index of the effectiveness of a therapeutic regime frequently encounters the problem of negative findings and lack of significance. This may be due to some extent to the difficulty experienced in isolating individual variables and their unique effects in terms of patient behaviour.

Similarly, the negative findings in (ii) would lead to the conclusions that, in both contexts, the quasi-experiment has failed to demonstrate any superiority of bridging therapy over conventional therapeutic methods in terms of patient outcomes. Whilst this is true, there are again two reasons why this conclusion should be viewed cautiously:

(A) Re-hospitalisation Rates

More than 50 per cent of patients in the control group in Sheffield were re-hospitalised for long periods during the follow-up phase. By contrast, only two patients in the experimental group were re-hospitalised for a relatively short period of two weeks during the follow-up phase (see results chapter, Table 5.3). This leads to the reasonable hypothesis that bridging therapy may be superior to the conventional regimes in controlling relapse rates following discharge from hospital - but this hypothesis would, of course, require further careful investigation. The differences of the relapse rates between

the two groups in Cairo was, however, much less pronounced than that of Sheffield (see 5.2.2 in the results chapter).

(B) Linearity of Recovery Rates

Linear trends in Figures 5.1 and 5.2 show a clear trend towards superior recovery rates in experimental as opposed to control groups. However, the small numbers in each sample made this trend impossible to demonstrate further, though it may prove to be statistically significant in larger samples.

6.2.4 Use of a New Behavioural Instrument

Problems and limitations of the BAI are discussed in detail in the methods chapter. Here it is important to illustrate its limitations in relation to the study in more general terms:

- (i) The BAI₁₀₀ was initially used without full behavioural validation, although some systematic assessment of its practical items was carried out. This early work indicated the urgent need to improve its validity. Nonetheless, initial data collection in Sheffield was completed using the BAI₁₀₀
- (ii) The BAI₃₀ was then developed and used for retrospective re-evaluation of the Sheffield sample, using the data obtained by means of the BAI₁₀₀. This procedure could lead to some limitations, such as rater bias, selectivity and the difficulty of conducting cross-validation studies;
- (iii) Despite the structural propensity of the BAI₃₀ to study the health adjustment, as opposed to illness aspects of patient behaviour, it

was confronted with similar problems to those which faced the PSE in regard to "borderline" cases - that is, precisely where to draw the line between "health" and "ill-health". As in the case of the PSE, such issues were resolved on the basis of clinical judgement.

6.2.5 Use of Unobtrusive Measures, Data Redundancy and Observer Time

The principles of action research required full participation of the researcher as a member of the therapeutic team. This necessitated spending extremely long hours with patients in the role of therapist - frequently extending from 9.00 am to 7.00 pm - in addition to home visits in the evenings and at weekends.

These long hours of work resulted in the accumulation of large amounts of rich qualitative data, which could not all be included in the study.

However, the richness of these data was necessary for qualitative analysis of the action research outcomes and presentation of the case studies.

Other limitations of this technique in terms of subjectivity, selectivity, researcher bias, halo effects, and reliability of the data are discussed in detail in the methods chapter.

6.2.6 Cross-Cultural Differences

During this quasi-experiment, it was not possible precisely to predict the various cross-cultural barriers leading to possible confusions in the study. However, it was possible to categorise two sets of potential cross-cultural barriers, as follows:

- (A) Conflict between Sheffield cultural norms and the researcher's Arab cultural norms;

- (B) Conflict between Arab cultural norms and the Western ethos in which bridging therapy was developed.

Preparation for development and implementation of bridging therapy focused primarily on conceptual and methodological frames of reference. Those cultural issues which were considered were mainly concerned with the cultural backgrounds of Sheffield-based patients and Cairo-based patients in relation to each other; and not with the cultural background of the researcher. In Sheffield, the researcher perceived her role as that of neutral agent, whose function was to work within planned and accepted therapeutic programmes, without seeking to obtrude her own cultural norms and beliefs either on the patients or on other members of the therapeutic team. This assumption was based on her Western educational background and relatively good knowledge of English; which, it was felt, could help in resolving many otherwise problematic cross-cultural issues.

Though this assumption was theoretically reasonable, in practice a number of unexpectedly difficult problems were encountered, despite the initial six months' familiarisation period spent in the study context in Sheffield. These problems included:

- indications of racial prejudice on the part of some patients;
- a tendency on the part of some nurses not to accept the researcher, and to develop an attitude of rivalry towards her;
- communication problems with some patients due to the researcher's inability to understand their (to her) rather difficult Northern accents;
- some patients' perceptions of the stigma of mental illness, and their consequent refusal of follow-up services;

- some patients' negative images of research as "becoming guinea-pigs";
- lack of agreement on the part of some psychiatrists actively to encourage patients to participate in the study;
- the researcher's perceptions of some patients' lack of spiritual faith and its potential impact on their treatment.

Some of these problems were possible to resolve by gradually gaining the trust both of patients and staff. However, other problems proved insoluble; and recourse to alternative strategies was necessary in order to overcome these.

In Cairo, some cross-cultural problems related to the origins of bridging therapy were expected to appear; and certain contingency strategies were prepared to overcome these. However, many of these anticipated problems were resolved with minimal intervention from the researcher. Examples of anticipated problems include

- conservatism of some psychiatrists towards experimentation with therapeutic concepts new to Egypt;
- patients' and families' fear of the stigma of mental illness;
- acceptance of the researcher as a female therapist working with male patients, visiting their homes and meeting their families (a most unusual occurrence!);
- lack of community resources and facilities equivalent to those in Sheffield, to facilitate patients' rehabilitation programmes.

However, a number of unexpected problems also began to appear. These included

- extremely long interview sessions, usually lasting in excess of three hours;
- very highly-charged emotional accounts, often taking the form of verbal abuse of family members, which was difficult to control at the outset, especially in marital therapy sessions;
- home visits in Cairo were extremely difficult, due to traffic jams and the wide scatter of patients' houses in the greater suburbs of Cairo.

A direct result of the last problem was that a great deal of time was spent in travelling;; and the researcher had to work for twelve hours every day, from 9.00 am to 9.00 pm, except at weekends, to compensate for this loss. These cultural and environmental problems are illustrative of the many unforeseen factors which can pose a serious threat to such a study, despite careful preliminary consideration of the study contexts and likely problems.

6.3 Assessment of Therapeutic Effectiveness of Bridging Therapy

6.3.1 Bridging Therapy as Evaluation Research

Evaluation research in the field of psychiatric care is illustrative of the continuing search for a feasible design, based on scientific principles, yet which does not cause disruption to the phenomena under study. As illustrated in the methods chapter, such a design has not yet been found; and scientists continue to suggest different modalities which it is hoped could reduce the gap between positivistic and phenomenological approaches. In this sense, the present study of bridging therapy represents an innovative design within this emergent tradition of eclectic studies.

Griffiths and Mangen (1980) found that very little evaluation research had

been carried out in the field of community psychiatric nursing care. They also found that the organisational modalities in Britain are still geared towards task-fulfilment rather than the achievement of a fully-integrated service. This was clearly demonstrated in the study by Hunter (1978) concerning the evaluation of community-based follow-up of schizophrenic patients. This worker carried out a comparative evaluation of the effectiveness of the CPN service provided by nurses from Moorhaven Hospital in Devon. It transpired that their role was mainly to give "depot" injections of long-acting phenothiazines, and to assess the patient's ability to stay out of hospital for further periods of time.

Hunter's aim was to produce an evaluation research using strict experimental design. The results lacked statistically significant differences between recovery scores for experimental and control groups. Nevertheless, Hunter claimed that this did not disprove the value of continuity of care as delivered by the CPNs under study. Reasons given to account for this lack of significance were related to difficulties encountered in finding a definitive group of matched controls; uncontrolled variables like family support; and relatively early identification of the need for further treatment of the experimental group. Problems such as termination or withdrawal from the service; continued dependency; and the need to interrupt conversations in order to give patients chemotherapeutic injections, were also mentioned.

Nevertheless, these problems did not change the fact that the caregivers and the patients' families appreciated the service, and recognised the function of the nurse as an agent of the service, with its associations with the psychiatrist and with authority. These results led Hunter to recommend the importance of continuity of care based on a more active therapeutic

approach, providing guidance and assessment, and explicitly concerned with the caregiver or family as the focus of the work.

A similar study was conducted by Henderson, Leven and Cheyne (1973). This took place at the Ross Clinic, Aberdeen, in 1969 - at approximately the same time as Hunter's experiment. The study involved a multidisciplinary approach providing a domiciliary service known as the Domestic Psychiatric Treatment Service (DPTS). The team initially consisted of a psychiatric nurse, a psychiatric social worker, and a consultant psychiatrist. Weekly meetings were held to produce two-way reporting on patients, operational and treatment plans, and to facilitate communication with medical and other care agencies.

The basic principle of the DPTS was clearly different from that of the Moorhaven service. The service was provided by nurses working full-time in the community, whose main concern was with home visits. Results indicated that an increased number of patients were being referred to this service - that is, more patients were being treated in the community than in hospital. However, the results also showed that nearly 3.6 per cent of the total population (i.e. 251 patients) developed symptoms of a new physical illness; eight patients died, including two suicides; and 83 patients still needed continued DPTS. Henderson's results led to recommendations similar to those of Hunter. Again, assessment and reassessment of the relationship existing between patient and family was stressed; and the dynamics of the interview and of psychotherapeutic involvement were emphasised.

Such suggestions were implemented in the work of Paykel and Griffith (1983), who compared outcomes for psychiatric outpatients after a period

of follow-up using two different treatment modalities. The first group received outpatient appointments under the care of the psychiatric team; whilst the second group received community psychiatric nursing care, with the CPN as the main treatment agent. Here again, the two modes of follow-up care produced results indistinguishable in terms of clinical symptoms, social adjustment and family burden. Paykel and Griffith's results were congruent with those of Hunter and Henderson, in that they, too, failed to demonstrate significant differences between experimental and control groups in statistical terms; yet, like Hunter, the authors emphasise the greater satisfaction expressed by the group who received the community psychiatric nursing care.

Technical psychometric problems were encountered by Brooker (1984b), whose attempt to develop an instrument evaluating patient outcomes in response to CPN care was blocked by problems of validity and inter-rater reliability. His instrument consisted of thirty-one questions, in the form of a classified questionnaire reflecting patients' descriptions of their problems at initial and subsequent assessment interviews. Another attempt by Clare and Cairns (1978) to develop a standardised interview schedule was concerned with the assessment of social maladjustment and dysfunction in the community - that is, with pathology rather than with social adjustment. Although the authors have claimed high reliability for certain items, they encountered problems in defining some criteria, especially with regard to the assessment of patient outcomes outside the hospital setting. Similarly, Downing and Brockington (1978) implemented the Brief Psychotic Rating Scale (BPRS) and the Psychotic In-patient Profile (PIP) to assess levels of frankly psychotic symptomatology, achieving relatively high levels of reliability.

These studies have been presented because they act as clear indicators of the current debate concerning patterns of evaluation of psychiatric nursing services; and the difficulties encountered in finding valid explanations for lack of statistical differences in the obtained results. This situation indicated to the researcher that the current study would need to adopt a different research style from those of its predecessors. Bridging therapy thus ultimately differed in that

- (i) it adopted a "methodological mix" design, based both on quasi-experimental and action research principles. Therefore its results need careful study and interpretation within this context. This approach has the advantage of neither over-valuing positive results nor rejecting negative ones.
- (ii) it developed and standardised a new assessment instrument, the BAI₃₀, which achieved 100 per cent reliability and 75 per cent inter-rater reliability on almost all its thirty items, both in Sheffield and Cairo settings.

The BAI₃₀ adopts a rationale of assessment, based on the concept of healthy adjustment, which is somewhat different to more usual rationales exemplified in the work of Brooker, Clare and Cairns, and Downing and Brockington, based on pathological manifestations or symptomatology. It was designed specifically to fulfil the need for a standardised instrument for assessment of patient outcomes at different stages of bridging therapy; i.e. before, during and after active delivery of the therapeutic programmes. Data obtained by its means were closely congruent with data obtained using the General Health Questionnaire (GHQ).

This finding regarding congruences with a well-validated current instrument adds support to the validity of the BAI30 itself as a potentially useful instrument for assessment of patient outcomes in psychiatric nursing care. Development of the BAI30 was a complex procedure fraught with some methodological difficulties: yet it appeared to survive the various rigorous stages of systematic empirical testing carried out to ensure its appropriateness and sensitivity as a psychometric instrument. Details of these methodological problems and the process employed to minimise them are discussed in the methods chapter (Chapter 4). Nevertheless, it is important to stress that the BAI30 is still in the very early stages of standardisation; and that considerable further data regarding its use across numerous samples will be required before it can be considered generalisable in a true sense.

6.3.2 Bridging Therapy in its Cross-Cultural Context

The practice of psychiatry and psychiatric nursing places great emphasis on the importance of human communication. In that sense, research in these areas is subjective, depending on the individual interpretation of language; facial expressions and other social signals; and the resultant perceptions and understandings of patients, families and therapists. Cross-cultural factors involved in the bridging therapy study comprised two main areas: firstly, the researcher's ethnicity in relation to the Sheffield sample; and secondly, the application of Western-inspired assessments and treatment modalities to Egyptian patients who may be unused to these types of intervention.

In the researcher's case, any initial language difficulties, or failures in perception of Western cultural values and norms, were hopefully to be minimised by her exposure to regional English idioms and ways of life

during a six-month orientation period spent in Sheffield at the start of the study. It was also hoped that her in-depth participation in hospital- and community-based therapeutic activities would help her understand, and become familiar with, various cultural differences in expectations and lifestyle.

Though language difficulties for the researcher in Cairo were clearly not an issue, communication problems were still encountered. These appeared to be due to the patients' differing perceptions of the researcher's role as nurse-therapist. Some patients and their families from less educated backgrounds appeared to view the researcher's intervention predominantly as that of a social worker rather than a nurse. However, on other occasions they would seek her advice regarding medical problems. Such apparently variable perceptions may be explicable at least partially in terms of the traditions of Egyptian folk medicine.

Traditional healers tend to deal with the patient's problem irrespective of its physical, psychological or social origin. The consultation is always in public and within the patient's social circle. This would explain the tendency of the patients' families to gather round their sick member whilst the researcher was conducting therapeutic sessions. On some occasions, it was difficult to see a patient privately without the presence of family members. Due to these circumstances, interviews would commonly extend to three hours or more, with all adult members of the family or extended family taking part in the discussion. Indeed, in some sessions as many as eight family members would participate.

In addition to language and communicational issues, there was also the fundamental issue of developing mutual trust between patients, other

members of staff, and the researcher. This proved to be particularly difficult in Sheffield. In general terms, the development of trusting relationships with patients is the most important and challenging task for a nurse-therapist. The situation becomes trebly difficult when a foreign psychiatric nurse is faced not only with gaining patients' trust, but also that of other members of the therapeutic team - including nursing colleagues, some of whom initially perceived the researcher's role as that of a "spy" who would report their activities. This misunderstanding about the role of an overseas researcher was not easily resolved; and it was only through the researcher's full participation in the daily routine work of the ward and day hospital that first acceptance, and later trust, were developed.

Various concerns about the implementation of bridging therapy were initially expressed by some members of the therapeutic team. Concern was expressed regarding the problem of shift work; priorities between hospital and community; skills necessary for home visits and family involvement; allocation of time; and the potential ward overload which might be produced by former patients coming in for a chat. Some of these problems were complex, and could have inhibited progress of the study. Fortunately some problems were resolved due to extra effort on the part of some staff members; and to the adoption of a therapeutic community approach to care in Ward 56 (more detailed discussion of which will follow).

Concern was also expressed by some patients, a few of whom refused to co-operate or to participate in the study, being afraid that the stigma of mental illness would follow them from hospital to home. Others said that, as soon as they left hospital, they wanted nothing to remind them of it.

Conversely, the situation in Cairo went against all expectations. It was

initially expected that the concepts of community care and of bridging therapy would be rejected by the hospital manager and the patients due to their unfamiliarity. On the contrary, the medical director of El Niel Hospital welcomed the study very enthusiastically and was highly co-operative; a situation which greatly contributed to the smooth running and success of the Cairo phase. Similarly, Egyptian patients also welcomed the idea of home visits and co-operated in the study. This may have been due to some degree to their perception of home visits primarily as a social event; whilst others saw it as a sign of friendship.

In Sheffield, the bridging therapy programme consisted of a series of interventions planned with members of the hospital staff involved in the care of each individual patient, including the consultant and other patients. A notable feature of Ward 56 was the excellent level of co-operation between members of the therapeutic team, helping the patients to become involved with a number of therapists from various disciplines ("therapists" here refers to people concerned with the therapeutic plan, e.g. social workers, nurses, psychologists and occupational therapists) who dealt with various problems accordingly.

Through bridging therapy, the idea of including hospital services as part of "community care" was introduced. During the period of the study, the nursing staff on Ward 56, who were extremely autonomous and responsive, introduced three valuable innovations on their ward. The first was the "Green Telephone" - a direct line to be used by patients after their discharge, if they needed to talk to their nurse-keyworker. Separate from the hospital switchboard, this line provided patients both with access to ward staff without going through unnecessary difficulties; and with assurance of confidentiality. It also enabled staff to ring patients back if

they ran out of cash in a telephone box, or were otherwise cut off. This innovation was very useful in eliminating some of the problems experienced by patients living on their own or who suffered feelings of loneliness or despair after leaving hospital.

The second innovation was the establishment of a "post-discharge group". This was a voluntary service provided by the ward-based nurses, a social worker and the researcher. The idea was to meet with discharged patients for a social chat and soft drinks. The purpose of this group was to help patients readjust socially; meet on a social basis; mix with other people in a community setting - e.g. in a pub - and practise ordinary living without being over-occupied with their problems. This service helped ex-patients to see other dimensions of social life and, for a brief period of time, to stop being overwhelmed by their problems.

The third innovation was the inclusion of some home visits for some patients during their period of hospitalisation or after discharge, if their therapeutic programme necessitated such a service - e.g. for purposes of behavioural programmes or domestic assessments. This service was again provided on a voluntary basis and proved extremely useful for purposes of the behavioural therapy programmes involved in the study. Emergence of these three innovations added considerable support to bridging therapy techniques.

In Cairo, implementation of bridging therapy in the El Niel Hospital was also successful in adding a new dimension to the routine care of patients. Involvement of the researcher in decision-making regarding detailed individual care plans during hospitalisation tended to shift the emphasis of care from a purely medical-biological model to a psychosocial model. The nursing elements of care plans had previously been decided by the medical

team. This was changed during implementation of bridging therapy, since the researcher provided the necessary nursing input to the planning phase.

Egyptian patients' experience of bridging therapy also appeared to change their perceptions of psychiatric treatment in a mental hospital (i.e., therapy is not only medication). This was manifested through many requests made by patients not involved in the study to talk and discuss their problems with the researcher, claiming they felt "less apprehensive" afterwards. Similarly, the concept of "follow-up" changed, since it became a nursing activity as well as a medical activity. Doctors were also enthusiastic about the integration of their own follow-up service with that offered by the researcher. In both Sheffield and Cairo, therefore, the impact of bridging therapy appeared both noticeable and useful, both to patients and hospital staff concerned.

6.3.3 Bridging Therapy as a Model for Comprehensive Community Psychiatric Nursing Care

Generally speaking, the inclusion of hospital services as part of the community care service is a step on the road towards a comprehensive community mental health service as envisaged by several authors as early as 1968. Sir Denis Hill (1968) defined such a comprehensive system as follows:

"If it is accepted that the aim is to provide comprehensive psychiatric care for a defined population, then the service must include hospital provision both for the chronic sick and the acutely ill, and the whole range of therapeutic and supportive measures for the whole community, the children and the aged, without limitation by age, diagnosis, social circumstances or anything else. In such a system the hospital is not an alternative treatment facility but is an integral part of a network of interdependent services."

and a similar view was expressed by Freeman (1968) who felt that

".....it would be better, in general, if we did not use the term "outside hospital" because hospital is part of the

community and provides one of its services."

More recently Amesbury (1983) suggested a similar view, despite a fifteen year time difference. She noted that

"Our goal should be the development of a comprehensive mental health system that incorporates the inpatients' state hospitals with community psychiatry."

Despite these suggestions and despite the reasons for change, both health authorities and CPNs continue to perceive community care as an alternative to hospital care and measure the success of the system by the length of time psychiatric patients spend outside the hospital walls, regardless of the deterioration in the quality of living of such patients. Bennett (1979) criticised British society for using the term "community care" without understanding its components; he stated it would be more appropriate to use the word "de- institutionalisation" which describes the current services. He explained that the current system has resulted in an inhumane standard of living for long-stay patients who are now forced to leave the hospitals even if they are in need of direct supervision for long periods of time. Bennett was unhappy about the financial limitations used as an explanation for the slow process of de-institutionalisation. In addition, he questioned the political decisions of trying to achieve economies in psychiatric care. He added

"There has been some abuse of community care in Britain when patients have been discharged, to seaside hostels without adequate preparation or support, but abuse in community care is much less commonly reported than abuse in mental hospitals."

A similar situation was recognised by Lamb (1979) who conducted research into psychiatric patients living in a 'board and care' home in California. The study included 101 psychiatric patients in one of these homes.

Lamb found that 92% were diagnosed as psychotic and almost a third (32%) manifested severe overt major psychopathology; 42% had lived

there continuously for five years or more and almost a third (31%) had been hospitalised during the past year. Nine people had never tried living alone or had experienced failure the last time they had tried; twelve people, who were recognised as insightful, became anxious and overwhelmed in social or vocational situations. He concluded, therefore, that those patients tried to find a place of asylum from life's pressures where they could get support and treatment; consequently they created new asylums in the community.

Bennett also supports the comprehensive system of community support which indicates

"There is a need for adequate community supporters - not only from community agencies but also from hospitals, which, although some critics forget it, are both part of the support system and part of the community."

The above view supported bridging therapy as an integral service which includes the hospitals as part of the community service. It is not fair, on the part of mentally ill patients, to be under the threat of being 'kicked out' of the hospital if they are explicitly in need of intense rehabilitative care.

The current system of mental health service appears to follow the provision of specific forms of care that are determined by fashion rather than by a realistic analysis and assessment of patient needs. It is quite understandable that the degree of independence varies widely and is very much influenced by surrounding circumstances. Sometimes it appears that mentally ill patients are treated as different creatures from the rest of human kind, ie in planning the health service for this group of people it would seem that these patients are pushed to reach certain standards of independence above their capabilities.

On the contrary, patients should be assessed at two levels, a minimum and optimum of their specific potential health adjustment before the development of the illness, accepting the fact that some residual damage may have become permanent. In more practical terms, bridging therapy has mirrored such aims.

The bridging therapy study tested the following principles:

1. Patients, their families, care givers or friends were supported, consulted and educated according to a planned programme based on a systematic assessment of patient needs. A good example of this is the case study of Sherifa (page 355), whose family was the main source of her troubles. By means of consultation and education they have been helped to develop an understanding attitude and to become the main source of her support.
2. Bridging therapy was geared towards immediate intervention so that psychiatric patients could cope with their difficulties without any unnecessary delay resulting from waiting, eg for an out-patient appointment, or the limited working hours of CPNs (9am - 5pm). A good example of this was the case study of Ronald (Appendix 21), who had a sudden relapse of psychotic persecutory delusions when a new male ex-patient moved into the halfway house where Ronald was staying. Discussion with Ronald and another ex-patient whom he trusted resulted in useful reassurance. It was also found to be helpful to initiate conversation with the new resident in the presence of Ronald, which calmed him down. An urgent appointment was arranged for Ronald to see his psychiatrist at the out-patient department; again this was helpful for Ronald, lessening his tension, as he trusted

his psychiatrist.

3. Bridging therapy was delivered according to each individual patient's needs which eliminated the difficulty of trying to fit patients to a structured programme, ie therapeutic programmes were tailored for each patient. A good example of this is found in the case study of Geoffrey (page 277), whose needs for parenthood were accepted by the researcher but at the same time he was encouraged to accept help and treatment.
4. The therapeutic techniques employed in the bridging therapy were eclectic in nature and did not focus on a specific school of therapy. This was quite clear in the cases study of Julie (page 301), who was helped both by individual approaches and a group approach, dynamic, psychosocial and behavioural.

To summarise the above arguments, the researcher believes that community psychiatric care is not an alternative to hospital care but is part of the same care. Therefore the bridging therapy study could be considered as a practical contribution towards the development of a comprehensive system for the psychiatric nursing service.

Some important implications arising from the bridging therapy study are discussed in the following section.

6.4 Discussion of Results

6.4.1 Discussion of the Quantitative Data

The quantitative method of data analysis showed significant improvement

in all groups. However, there was some trend towards a higher improvement for the experimental than for the control groups in both Sheffield and Cairo. Three issues are of considerable importance and require further discussion. These are:

- (A) Comparability of BAI₃₀ with GHQ scores;
- (B) Possible reasons for lack of statistical differences between experimental and control groups;
- (C) Possible reasons for lack of statistical differences between discharge and post-follow-up scores.

Each of these issues will now be discussed in further detail.

6.4.1.1 Comparability of BAI₃₀ with GHQ Scores

There was consistency in improvement for both British and Egyptian samples. Generally speaking both samples, in Sheffield and Cairo, scored similar levels of improvement on the BAI₃₀ and the GHQ. Furthermore, no significant difference was found in the EPI between both samples. Against all expectations, the degree of improvement was almost identical despite the differences in contexts.

These results also indicate a consistent tendency for improvement in general, whether the patients are British or Egyptian. The use of the EPI helped to screen the personalities of patients in both samples. The results revealed that both groups were homogeneous.

Similarly a consistent relationship between the scores of Egyptian and British samples on the GHQ was also found. This indicates that both patients and their raters had independently judged the problems to be similar. These results are quite important, indicating that overcoming cultural barriers could be achieved through the use of explicitly phrased criteria for each item of assessment and by means of patient responses or questionnaire, to verify the results obtained.

Many reasons could be considered relevant. One might be that patients who accept hospitalisation are generally suffering from difficulties which affect their capacity to cope. Professional help during hospitalisation usually reduces patient anxiety resulting in better ability to deal with problems. The results obtained support the effectiveness of hospital care in terms of rapid intervention in acute cases.

Another explanation could be the patient's desire to get better in order to please the therapist or to gain a sense of achievement. A third explanation could be that disruptive behaviour occurring during hospitalisation would be quickly seen and suitable intervention would take place as and when appropriate. It can thus be seen that in both Sheffield and Cairo patients showed a consistent tendency for improvement which was almost identical.

Yet another explanation would be the influence of the therapist on the patient's decision. Some patients would feel they were improving after hearing words of encouragement from the therapist; yet others who had developed more insight into their problems might have a tendency to over-rate their difficulties and seek professional help. This latter point was particularly true for the Cairo patients, whose scores on the GHQ were

congruent with those of the BAI₃₀ as scored by the consultant and researcher; whereas the Sheffield patients' scores on the third interval of the GHQ were not consistent with their corresponding scores on the BAI₃₀. However, it is important to stress that cross-cultural studies usually find difficulty in obtaining significant agreement about the determination of mental illness. This appears clearly in Baskin's (1984) study where a questionnaire was sent to more than 110 countries, asking their mental health professionals to diagnose a number of cases included in the questionnaire. The answers varied widely across the countries, revealing that the adoption of the DSM III in the US has done little to mitigate this.

The differences between Egyptian and British assessment manuals could be less varied since the Egyptian Psychiatric Association has developed a Diagnostic Manual of Psychiatric Disorders (DMP -1) based on the International Classification of Disease, ICD-8 and ICD-9, (Gawad 1981).

6.4.1.2 Lack of Statistical Differences between Experimental and Control

Groups:

There was a lack of statistical differences between the experimental and control groups in both samples. This result is one of central importance, indicating that the behaviour of the control group was similar to that of the experimental group. Therefore no statistical significance was recorded, ie bridging therapy did not show a significant improvement over the conventional system. Strictly speaking this is correct. However, detailed examination of associated factors have revealed a different view. One of these factors is the patient's potential for normal remission even without therapeutic intervention. Eysenck (1960) compared "no treatment" with "psychotherapy"; no statistical difference was found. Sloane's (1975) results were similar,

ie psychotherapy and behavioural therapy were compared with "no treatment". Again no statistical differences were found between the three groups.

Lambert et al (1978) stated that 43% of the clients recover 'spontaneously'; while the figure increases only to 65% with psychotherapy. In a more recent study, Wilkins (1984) found that psychotherapy results were analagous to those obtained with chemical placebos.

Similar results were obtained from studies on community care; eg a comparative study of chronically ill psychiatric out-patients, carried out by Slavinsky and Krauss (1982) in the US. Two groups of patients were involved in this study; one group received social support from a programme that was provided by nurses, as well as maintaining the prescribed medication. The other group was only a medication clinic, providing minimal contact with a physician or psychiatrist twice each month. Interesting results were obtained; after one year of treatment the social support group was changed significantly in only two aspects; firstly, they were independently functioning in their occupational roles, and secondly, they were less satisfied with their care, whilst the medication clinic group expressed more satisfaction with the care provided and less independent functioning. After two years of treatment they found that the medication clinic group, rather than the social support group, improved. In addition the social support group experienced increased depression and agitation and some of them were re-hospitalised. Slavinsky and Krauss' explanation of these findings was that patients may prefer the low stimulation, low interaction model of the medication clinic to the high stimulation interactive model of the support groups. Another possibility was that the initial symptoms of the social support group could have

exacerbated an increased response anxiety generated by the initial stages of group therapy.

In conclusion, their findings were completely contrary to the initial hypotheses but were supported by other researchers' findings which suggest that socially-oriented therapy at its best is beneficial to the effects of medication; and at worst interacts negatively with goals of medication maintenance.

The findings of Slavinsky and Krauss support the findings in the current study. As shown in Tables 5.6 and 5.9, both groups in Sheffield and Cairo settings had considerably improved. The Sheffield groups (experimental and control) were receiving well-established psychosocial programmes both in hospital and in the community. In the Egyptian groups (experimental and control), apart from the bridging therapy programme, the patients' main form of treatment was the custodial model implemented by medical staff. No organised or established psycho-social therapeutic programmes were available for them. Nevertheless significant improvements, equivalent to those of the Sheffield groups, were achieved.

Another explanation of this phenomenon could be related to the social structure of the communities in Sheffield and Cairo. As seen in Table 2, patients in the Sheffield group were mainly living on their own, or in supervised hostels; therefore their need for the availability of community resources would be essential, whilst none of the patients in the Egyptian group lived on their own.

The family in the Egyptian context was the main social resource. El-Islam (1982) carried out an investigation into the therapeutic effect of the

family on Qatari schizophrenic out-patients who lived with their families. His results indicated that patients living in a supportive extended family were significantly improved compared with those living in a nuclear family. Such findings could explain the implicit therapeutic effect received by the Egyptian groups, both experimental and control. This could be one reason for the lack of statistically significant differences between both groups during hospitalisation and, more importantly, during the community follow-up period. The opposite is true for the British society where the extended family has less influence on the family members (Mangen 1982).

Mangen reviewed some of the studies of the British family burden, where some member(s) of the family look after their mentally ill members, indicating that the price relatives had to pay was

"... a decline in their own mental health; 40% said that it had deteriorated. Almost one-third complained of adverse effects on social and leisure life and on domestic routine. One in ten families experienced reduction in family income ... for the children: over a third of them had had emotional problems or problems with schoolwork."

These findings are analagous with El-Islam's (1982) findings with Arabian families in Qatar. The nuclear family is less effective in the supervision of its ill member's treatment, less tolerant of the burden he imposes, and has a more negative influence on the patient's improvement. Anxieties concerning the cause of mental illness, its treatment and the future of patients were expressed by families of patients who were hospitalised for the first time.

The foster family idea was experimented with by Pierloat and Demarsin (1978) in America and by Polak and Kirby (1976) in the UK. Results in both studies supported the usefulness of involving mentally ill patients in family life situations in order to help them to re-adjust to social life.

The effectiveness of family care versus hospital care in India, as a developing country, was studied by Shailapai and Nagarajaiah (1982). They compared the outcomes of two models of delivery of care; one modality was the traditional hospital model offering initial admission on the wards of the hospital and subsequent out-patient follow-up at the hospital out-patient department. This modality has been used as a control group model. The experimental model offered the delivery of care to the patients within their homes from a nurse who visits the house periodically and who is trained to carry out the follow-up task in terms of counselling, therapeutic intervention and primary medical/nursing care. This group of patients was not hospitalised. All patients in the experimental group were newly diagnosed schizophrenics and living with their family. The comparison of the results between the two groups in terms of clinical pathology, showed statistically the advantages of the experimental group, with a better social functioning and a reduction in the burden experienced by the family. These results are similar to those obtained by Mangen and Griffith (1982b) in the UK.

Such researchers suggest the valuable role played by the family in relation to patient progress which is equally supported by the current study. On the other hand one should note that generally speaking the improvement gained by the experimental group receiving bridging therapy continued to be higher than that of the control group. The difference was not statistically significant but the experimental group showed a consistent tendency for improvement, while the control group was more or less maintaining the level of improvement achieved during hospitalisation (Figs 1 and 2). In other words these findings suggest the usefulness of bridging therapy to increase the tendency for achieving higher levels of improvement.

Another factor could be the early detection of difficulties experienced by the patients in the experimental group and intensive efforts provided to help them to deal with them. An important feature of these results showed that both experimental groups in Sheffield and Cairo achieved levels of improvement during hospitalisation which were statistically highly significant (Fig 5.1 and 5.2) as scored by BAI₃₀. This finding suggests the significant value of hospital treatment in terms of controlling disturbed behaviour for both Sheffield and Cairo samples.

These findings could be related to a number of reasons that have led to the slight improvement recorded by the experimental groups. In other words results here may be attributable to the extra time and effort spent on the part of the researcher with patients from the experimental groups; eg joining their outings or arranging social events with them as shown in the case study of Geoffrey.

6.4.1.3 Lack of Statistical Differences Between Discharge and Post-Follow-Up Scores:

There was a lack of statistical significance of the post discharge scores in comparison with high statistical significance of the hospitalisation scores. A related controversial point is that the findings of this study may appear to support the hospital treatment over bridging therapy as the main significant differences were between admission/discharge scores. In other words, the improvement during the follow-up period of the experimental group is not statistically significant (as shown in Tables 5.6 and 5.9).

It should be noted that one interesting finding was the higher relapse rate, as undoubtedly readmission to hospital, or in one case a prison sentence

arising from his problem, in the control groups compared with the experimental group. This was particularly so in the Sheffield study where six of the eleven control group relapsed compared with three of the experimental. Because of the very small numbers involved no statistical or clinical conclusions can be drawn.

In the Cairo sample, the numbers were even less conclusive, with three of the control group out of nine relapsing compared with one patient of the experimental group.

Further examination of this phenomenon again would explain that the lack of significance is not due to lack of improvement but completely the opposite, ie the consistency of improvement. To explain this: many patients from the experimental group were able to achieve the optimum levels of improvement on the assessment scale BAI_{30} , ie many of them had a discharge score of 4 or 5 on most of the items. Therefore maintaining and improving this level of patient improvement during the follow-up period of bridging therapy would support the consistency of improvement but would not show statistical differences. Therefore the differences between hospital admission and discharge were significantly high due to the considerable improvement on the BAI_{30} scores, eg patients on admission were scored 1 or 2, on discharge they were scored 4 or 5. This feature was true of both experimental and control groups on admission and discharge.

Interestingly, the experimental group in the Sheffield sample has shown more improvement than that of the control group regarding the follow-up period. As shown in Table 5.7, the Sheffield experimental group showed a significant difference at $p < 0.01$ for admission/discharge scores. This significance was even higher, $p < 0.001$, for admission/post-discharge

scores. This feature could be explained in the light of the number of items scored at the optimal level of achievement on discharge and post-discharge. On the other hand the control group scores were also significant at $p \leq 0.01$ on admission/discharge and preserved the same level on admission/post discharge.

To reinforce these results, the GHQ scores were compared with the BAI₃₀ measurement; in other words patient perceptions of their condition or improvement were compared with that of the researcher's and consultant's clinical judgement.

It is of interest to note that the statistical analysis of the GHQ scores in both contexts was very much concurrent with the BAI₃₀ measures, ie statistical significance was obtained on the analysis of scores on admission/discharge and admission/post discharge of the GHQ. Again no significant difference was obtained between discharge/post-discharge or between experimental and control groups of both samples, as shown in Tables 5.5 and 5.8. One problem is noted in Table 5.10, that the admission/post discharge difference of the Egyptian experimental group was not significantly as high as that of the Sheffield experimental group. This could be related to environmental aspects.

In other words, the patients' capacity for adjustment and progress could be very much influenced by environmental conditions. Dooley and Catalano (1984) found significant correlation between loss of job, undesirable job, financial events and increased psychiatric symptoms. Similar results were obtained by Dohrenwend and colleagues (1984) who found that hassles and everyday stress was confounded with measures of psychological distress.

Similar investigations were carried out by Cohen and colleagues (1984), to study the relationship between negative life events and psychological disorders as well as the roles of positive life events and received/perceived social support in moderating this relationship. A significant correlation between negative life events and psychological disorders was demonstrated. However, the study also revealed non-significant correlations between positive events and psychological disorders or the received social support.

Closely following this line of research is the work by Murrell and Norris (1984) who studied the interaction between desirable events and undesirable events with the maintenance of progress in older depressed patients. Results supported the significant improvement of patients who initially had stronger resources over those with weaker resources. Also those with higher desirable events showed less decline in positive affect. In addition, detailed analysis showed increased depression was significant in correlation to combined condition of weak resources and high levels of undesirable events. In general, weak resource persons with low or moderate undesirable events showed modest improvement in depression.

Along similar lines was Kirk's (1976) finding on the variables of readmission. He found that readmission was significantly high among patients with less income, lower status occupations, unemployed and those who were not initially referred to the hospital by themselves or their families, ie living on their own. Although Kirk's study took place in Kentucky, in America, yet these findings were analogous to those of Brown and Harris (1978) in England, who studied the relationship between depression and divorced women from under-privileged backgrounds.

These studies could explain the problem illustrated in Table 5.10, which indicates that patients in the Sheffield group, with their access to different sources of support in the environment, in terms of housing, financial support, and rehabilitation facilities, were able to achieve higher levels of improvement than those in the Cairo sample who were underprivileged in that respect.

From a statistical point of view no strong evidence was obtained to support the superiority of bridging therapy over the conventional model of care, either in Sheffield or in Cairo. On the other hand the statistical analysis did not disprove its effectiveness, ie the conventional system was not shown to be better than bridging therapy.

Bridging therapy, statistically, was shown to be better than the conventional system in terms of maintaining and increasing the tendency for improvement. Factually, bridging therapy results continued to be higher for both experimental groups in Sheffield and Cairo.

6.4.2 Discussion of the Qualitative Data

6.4.2.1 Patients' Perceptions of Their Problems

Patients' clinical diagnosis was not the most important criterion for developing the therapeutic plan. Instead the dynamics involved investigating, discussing and analysing patients' problems and their reactions to them. By such means patients' difficulties/problems or illness were perceived from a holistic point of view, that gave meaning and life to any diagnostic term, eg 'depression'. The four patients in the reported case studies, each had the diagnosis of depression, yet each case

was unique in its expression of depression and in the patient's reaction to this depression. The fact that many of the initiating factors for depression had similar origins did not change the uniqueness of each individual's reactions. The environmental element (whether concerned with social, family relationships or work situations) was recognised to greatly influence the development of these problems (Goleman and Speeth 1982). As the individual is in continuous interaction with the environment, so the development of such problems is always a common possibility. However it is unrealistic to think that the complete avoidance of such problems is achievable. Instead, patients should be helped to view situations and problems from a practical point of view. Patients' reactions and perceptions of their own problems is a major area for successful intervention to take place.

As individual perception can go through a process of change, therefore the researcher was able to concentrate her efforts on visualising the patients' problems from a comprehensive multidimensional viewpoint and trying to help the patient to correct negative perceptions. Each of the previous case studies presented a good example of the applicability of such a premise. In the case study of Geoffrey, he refused to acknowledge his problems and denied the need for any assistance. Such a denial was not accepted by the researcher or other members of the therapeutic team as his behaviour was particularly threatening to his personal safety, his family safety and his work safety. Here the researcher recognised the conflict experienced by GR who perceived his role to be that of a father and a policeman, capable of helping and assisting others; at the same time he could not accept the role of a patient who was in need of help and care. Some people who react to the term "help" should be dealt with using extreme care as the term conveys to them being helpless, weak and

redundant.

Therefore it was very useful to approach Geoffrey with the acceptance of his willingness to give, to be a father figure to other patients on the ward and to the researcher herself. Antagonism towards the patient at the early stage when he was choosing what role he should play would have inhibited a trusting relationship from developing. Later on in the relationship he proceeded from a parent/child relationship to an adult/adult one.

A similar situation was again encountered in the second case study, when Julie wanted a parent figure who would give her genuine, unconditional love that she had missed during her childhood period. The conflict between what Julie wanted and what the researcher wanted (as a therapist) began to appear at a later stage of the treatment, when Julie's perception of therapy failed to understand the nature of the progress required to obtain a mature responsible effective life. However this conflict was subsequently resolved as Julie changed her strategies from merely receiving to participating.

In the Egyptian case studies, the nature of the problems were quite similar to those in Sheffield. In Appendix 22 is the brief case study of Mr Fahad, similar to that of Geoffrey. Mr Fahad had difficulty in acknowledging his problems and his need for help. He adopted a fatherly attitude towards the researcher and agreed to participate only to help her with her studies. Ironically he perceived that his daughter was the one who caused all his problems. He could not see the problem from any other dimension and to him therapy was to forget what had happened and to deny having a daughter. The problem was quite complicated to deal with,

especially because of his cultural and social background which puts great emphasis on the daughter's behaviour and that any unacceptable behaviour should be dealt with by him with severe punishment. Therapy helped him to reach a better understanding of the situation and to reach a reasonable level of acceptance by recognising the positive side of his daughter's behaviour.

The results of denial of problems and of bottling them up was demonstrated by another case study, that of Yassin, who claimed that he did not have any problems and that he had realised what 'mistakes' he had made in the past and that he did not want to talk about them any more. The conflict here was in Yassin's perception of what is right and wrong. It appears that Egyptian society does not easily accept human limitations and lacks a positive understanding of circumstances that might force some people to pursue certain behaviour which could be described as 'shameful'. Therefore the researcher's approach was to convey to Yassin a non-judgemental understanding of his problems, together with acknowledgement of the limitations of human beings and acceptance of him just as a person. The relationship began at the adult/adult level of interaction and moved very quickly from complete rejection of the researcher's efforts to complete acceptance and trust at a very deep level.

The effects of a 'shameful experience' are not an uncommon cause of psychological disorders. Although the term 'shameful' is usually determined by society and culture norms, yet at the same time it greatly influences the individual's perception of what constitutes shameful. The case study of Sherifa is a clear example of such an issue.

Sherifa perceived herself as being fooled by somebody who took advantage of her needs for love and acknowledgement. However, she perceived herself as guilty of getting married or trying to establish her personal independent life without her family's knowledge or approval, even though the one she loved was quite keen to get married to her. When things did not work out as hoped for, she was the one to blame, suffer and be punished. According to her, and society's norms, she judged herself guilty and tried to commit suicide.

This complicated situation of Sherifa's would reinforce the importance of visualising each individual patient from a holistic point of view so that the patient's problems would be investigated in meaningful terms. Therefore the researcher tried to perceive this problem as multi-dimensional and to study different factors and predisposing factors that added to the development of the patient's problems. To explain this, for instance, the perception of other members of the family with regard to this problem was studied and the identification of the problem as perceived by the patient and her family. In other words, the researcher was concerned not only with changing the patient's perception but her concern was also extended to include the family.

The therapeutic relationship with Sherifa was mostly at the adult/adult level; however sometimes it seemed to swing to parent/child level when Sherifa was feeling weak and unable to make decisions regarding vital aspects of her life.

6.4.2.2 The Therapeutic Intervention Model

As has been explained earlier (Chapter 3), the Flexible Integrative Approach (FIA) was implemented. Similarities in symptoms did not

necessarily mean there were similarities in management. For example, in the problem of depression expressed by the four patients in the preceding case studies it is clear that all of them experienced troubling feelings of sadness, guilt, worthlessness and a tendency for suicide. Nevertheless the points of emphasis in their therapy varied with each case. One could argue that the use of chemotherapy helped in the improvement of patients both in Cairo and Sheffield hospitals. It is recognised that chemotherapy has a therapeutic effect but these effects may be limited to calming down a patient. Julie, for example, was in need of expressing her suppressed anger and chemotherapy was the best method for relieving her anger. Other problems associated with her lack of social skills, assertive skills or obsessional traits were not helped by chemotherapy. For these cases the use of psychoanalytical and psychosocial models was useful. On the other hand the researcher and the rest of the therapeutic team had to accept, in Julie's case, her decision not to interfere with her obsessional habits. This approach might have conflicted with the reality therapy approach used with Julie for other situations. Reality therapy should encourage the patient to behave responsibly; what Julie did, in fact, was to reply with what she thought the therapeutic team would want to hear, telling them that her obsessional habit did not interfere with her everyday life. It would have been unwise to insist on forcing the patient to change her habits as long as they were not disruptive.

Sometimes it may be misleading for the therapist to be obsessed with forcing certain models in order to change the patient's behaviour against his/her will.

In the Egyptian context, once again chemotherapy was not the answer for many problems. Chemotherapy did not improve Sherifa's ability to face

her family or her ex-husband or other people in her society.

Chemotherapy did not guide Yassin to the proper management of his marital problems.

One might say that there is confusion between medical problems and social problems. However no one can deny the fundamental principle of the continuous interaction between clinical and social problems (Wing and Olson 1979). Consequently individual reaction would vary according to his/her classification of the problem and what degree of disruption it may cause. Classification of problems as clinical or social was not distinctive, as appeared in the case study of Ms Vicky Carr (Appendix 23). Despite the fact that she continued to take her medication (phenothiazine) regularly, this did not alter her feelings of persecution for being black nor her feelings of guilt because of her shameful behaviour in the past.

Auditory hallucinations were controlled by the medication but she used to hear voices insulting her at times of distress. She felt happy and satisfied with her life when she had a job, a boyfriend and when her sister came to visit her from Japan. Here again reality therapy principles were significant. She experienced distress once more after her sister returned to Japan and her boyfriend moved to Leeds to start a new job (also their relationship had started to deteriorate) and eventually she committed suicide.

An important aim of therapy in general is to free patients from their handicapping problems and help them to achieve a reasonable level of independence. However in Sherifa's situation, financial and materialistic problems were an unavoidable threat to her freedom of choice and independence.

Being the eldest child she had to work at the age of 14 years in order to support the family financially. Once again the financial problems have destroyed her engagement and marriage plans as her family refused to finance her and her fiancé could not start an independent married life. Even after she and her ex-husband got back together again she continued to be threatened by her mother with being thrown out of the family house if she did not behave according to her mother's wishes. Sherifa would have been better able to resolve her problems if she could have had a council flat where she could start her married life.

The social nature of Sherifa's problem did not reduce the importance of implementing specific psychological approaches relevant to this context. Cognitive therapy would have been effective to use for Sherifa's condition, but both the researcher and the therapeutic team in the hospital lacked the practical experience to use this approach.

However the approach used did help the patient to see the factors that influenced her to behave as she did and try to replace her feelings of guilt and to stop blaming herself. She was able to realise that she was a victim of circumstances, such as the ill-treatment by her mother, her financial problems and her ex-husband's manipulative behaviour. The approach used here was based firstly on a psychoanalytical approach to encourage the patient to talk freely about her feelings and experiences without fear, distrust or moral judgement. Following this rational-emotive therapy was used to teach her how to perceive her problems through the factors that lay behind her problems. Reality therapy would reinforce her ability to handle different situations in a rational acceptable manner. Sherifa learned to be assertive enough to protect herself against the ill-treatment of her mother and manipulative behaviour of her ex-husband.

Although she was confronted with major problems in the following weeks after her hospital discharge, she managed to deal with them quite effectively with help and support so that one could say that the use of rational-emotive therapy was correct for effecting change in Sherifa's attitude. But this would not be very realistic as Sherifa had enough personality resources which functioned once 'dug out' by the rational-emotive therapy. Reality therapy guided Sherifa to stop the irresponsible behaviour of attempting suicide and led her to try to find some members of her family who would support her to whom she could relate.

Generally speaking Sherifa was able to make use of the therapy provided because she accepted the challenge for change. Quite different from her was the case of Geoffrey. He denied having any problems, refused to accept any help, adopted the role of policeman and questioned the other patients about their problems. An indirect approach by means of group therapy was used to help Geoffrey realise that there is no stigma attached to acknowledging one's own problems. Nevertheless Geoffrey continued to play the same game. The first time that he was able to open up about his troubled feelings and difficult problems was after he had received a phone call from his ex-wife accusing him of "forgetting his responsibilities and going mental". He asked the researcher to imagine herself as his daughter and judge his behaviour from that point of view. Supportive psychotherapy was very important at that stage as the patient suffered the pain of guilt and the pain of opening-up about his problems to a "stranger". Despite the negative effects of his ex-wife's telephone call, positive effects far outweighed these. It appeared that because of the telephone call his pain became intolerable and he needed immediate reassurance and support specifically from a "daughter" figure. This incident happened only two weeks before his hospital discharge. For one

month before this incident Geoffrey was not only fooling himself but also trying to fool the therapeutic team, which he might well have continued to do.

Insightful therapy was helpful in reducing his condition in conjunction with supportive psychotherapy and reality therapy. Insightful therapy was approached gradually to minimise the pain experienced by Geoffrey when he opened up about his problems and to give him some time to accept the need for change. As many of the problems were related to the family, involving the family with him in the therapy session and the management proved of great value.

The leading factor producing successful therapeutic results was the interview when both Geoffrey and his wife openly discussed their feelings and fears. The origin of the problems was identified and mutual misunderstandings were resolved. Acceptance of each other's point of view and a readiness to cope with some of the difficulties that had occurred in the marriage enabled this family to enjoy a more stable, secure life.

A few similarities to Geoffrey's case occurred with Yassin. Yassin was married with five children; one daughter was married and another was working for Radio Cairo; the other children were either studying at university or at secondary school.

Here again Yassin was annoyed with his second daughter for not keeping his first name with her surname. He considered that she was ashamed of his love affair with the Dutch woman and so ignored him. His wife, on the other hand, felt very bitter and hurt because of this and previous love

affairs. The story was rather different from Geoffrey's as the Dutch woman refused to marry Yassin, causing him a lot of pain, feelings of rejection and losing him his job. Supportive psychotherapy again was the first step to help him to open up.

As the phenomenological-existential model was the baseline, both Yassin and his wife were encouraged to correct or change their perception of each other's behaviour and reinforce the spiritual links between them. Although they were able to talk freely about many of their marital problems including sexual ones, yet this opening was not always helpful as neither of them was tactful, causing pain to each other and sometimes it was difficult to control the amount of aggression verbally expressed. Both Yassin and his wife gained further insight into their motives and behaviour and agreed to reach a compromise. However this compromise did not help to satisfy them and they continued to hurt each other from time to time. Wing and Brown's (1970) work demonstrated the negative attributions of such highly charged emotional expressions.

Reality therapy was useful here as it helped Yassin to appreciate his technical abilities and to take some responsibility towards finding another suitable job and to develop self control over his behaviour, eg getting violent or, at the other extreme, avoiding people.

From the above analysis of the four case studies it is clear that the researcher as a therapist was in a very difficult position. The aim of the therapy was to change the unorthodox, irresponsible behaviour. The spiritual aspect was very helpful in guiding patients towards specific norms of behaviour that would fit within a religious point of view.

From the researcher's point of view particular difficulty was experienced when dealing with patients in the Sheffield group who denied any religious faith or spiritual beliefs. This might be related to the researcher's religious background and beliefs. To explain this point, many patients lacked the motivation for life, had suicidal tendencies and claimed that life was not worth living.

Improving patients' perceptions of life through emphasis on positive rather than negative aspects, accepting one's own handicap and building hope for the future was difficult to deal with without reference to the spiritual value of life.

On the other hand this problem was not encountered with the Egyptian sample. Their religious or spiritual orientation had made it easier for the researcher to discuss their problems with them without deliberate efforts to avoid the spiritual aspects which were in every sense impossible to avoid.

It is believed that spiritual attitudes and faith in God can help in accepting difficulties of everyday life or to have hope of achieving a certain comforting state of equilibrium. Jung (1960) believed in the religious/spiritual importance of seeking meaning and discovering natural psychological power for healing,

"A religious attitude is an element in psychic life whose importance can hardly be over-rated. And it is precisely for religious outlook that the sense of historical continuity is indispensable."

Inclusion of religious beliefs as a part of therapy was specifically included in the school of logotherapy by Viktor Frankl (1967). He suggested that the use of logotherapy is not meant to be a substitute for psychotherapy

but to supplement it; and that the psychiatrist should feel free to function as a priest when the therapy requires it.

An important aspect of logotherapy is the belief that the unconscious God or unconscious religion is within everyone, even the irreligious. He also believed that it was up to the individual to commit himself along a religious path. He argued that through logotherapy the individual patient is led to believe in his ability to take decisions and to rule his own life.

Despite the acknowledgement of problems raised by logotherapy, such as freedom of will and existential conflict, it was evidenced through the course of bridging therapy that it was the patient's decision to make use of the services provided and to try to get better which was the decisive factor in improvement or cure.

As has been already mentioned, the approach implemented was eclectic, based on multiple psychological, social, phenomenological and behavioural approaches. Therefore reference to spiritual and religious beliefs was useful on a number of occasions.

To conclude this discussion, it is important to stress the positive effects of bridging therapy as appeared from the quantitative and qualitative data; yet one should not deny the fact that no proof of the bridging therapy's superiority over conventional models was obtained.

Nevertheless the experiment was a useful exercise in the sense of developing a new instrument of assessment for patients' adjusting behaviour applicable in different contexts, eg in or out of hospital, with British or Egyptian patients. The study was also a useful exercise for

examining the different philosophical bases of different theories of nursing or psychotherapeutic options that were helpful in reaching a better understanding of patients' problems and in shaping the implemented approach, the Flexible Integrative Approach. Support for the FIA was found in the writings of Spunt et al (1984). The study presented a good example of the use of both quantitative and qualitative methods of data analysis without conflicting outcomes.

Throughout the course of the study it became clear that any planned changes for improving patient behaviour are mainly in the hands of the patients and the environment rather than with the therapist.

Finally, the current study helped to examine the components of the term comprehensive care. The study showed the term is wrongly used and it is not possible to achieve comprehensive care by individual efforts, that is, to say that we can offer a comprehensive care plan for each individual patient is an illusion.

Many dimensions such as politics, finance, community attitude, research findings, advanced technology and ecology are all to be taken into account when thinking of comprehensive care. In general terms, bridging therapy could be useful if the existing organisational system of community care was more flexible towards including hospital care as part of the community care and permitted nurses to perceive their role as continuously expanding and extending towards more specialisation and advanced skills. This principle is not a new one; many other disciplines have adopted this attitude to provide a better service for the patient. In psychiatric nursing patients would receive a homogeneous form of care when the gap is crossed between hospital and community, with the assistance of the key worker. Hopefully this gap will eventually disappear

with the integration of the hospital service into the concept of "community care".

6.5 Implications of the Study

Four aspects of future development in psychiatric nursing may be expected to benefit from the outcomes of this study. These include developments in clinical, educational, organisational and research areas of the psychiatric nurse's work.

6.5.1 Clinical Implications

Firstly, the empirical testing of bridging therapy, using FIA as a therapeutic model for intervention, can encourage health workers to employ common-sense approaches within a conceptual frame of reference. FIA adopts an eclectic stance both in psychotherapy and in nursing process. This implies a considerable study by nurses of the differing schools of psychotherapy in order that a coherent, eclectic therapeutic plan can be developed.

Secondly, the development of a practical, valid instrument for the assessment of patients' healthy adjustment and various patterns of deviation from these norms (the BAI) has several clinical implications for psychiatric nurses. These include:

- (i) use of the BAI in assessing patients' condition, both in respect of deviations from healthy adjustment patterns and in respect of the recovery process towards an optimal health status relevant to each individual;
- (ii) use of the BAI within the context of multidisciplinary assessment, since its structure shares common ground with numerous specialities.

It is therefore usable by many health care workers, including psychiatrists, psychologists, psychiatric nurses and social workers.

6.5.2 Educational Implications

The concept of bridging therapy has interesting implications for nurse education both in Britain and Egypt. In Britain, bridging therapy demonstrates two important dimensions in curriculum development which could help improve the educational programme for psychiatric nurses. The United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC) has recently announced Project 2000, its new policy for the improvement of nurses' education and training along lines congruent with those followed in establishments of higher education (UKCC, 1986).

This project supports the holistic view of patient needs, and emphasises the establishment of links between curriculum development and community needs. In this connection, bridging therapy provides a practical guide to the development of a conceptual frame of reference supporting the holistic approach to patient care. It highlights the autonomous role and neutral stance of the nurse practitioner, which it is hoped may be achieved by the year 2000. It further emphasises expansion of the scientific body of nursing knowledge that is of central importance to nurses' professional maturation and related acknowledgement as a profession.

Secondly, the cross-cultural aspects of bridging therapy introduce a relatively new dimension to the education of psychiatric nurses in Britain. At the present time, both home and overseas nursing students receive a curriculum of education and training which caters mainly for Western

cultural needs, usually conceptualised in terms of the needs of educated middle class patients. This deficiency of educational provision in recognising, and catering for, the needs of ethnic minority groups in Britain needs an effective remedy as quickly as possible.

Thirdly, those responsible for the education and training of overseas students need to study the cultural requirements of the various developing countries; and thus emerge better equipped to prepare foreign nurses more appropriately for their future roles in their home countries.

Bridging therapy stresses the importance of preparing nurses to work with people, either on an individual or on a group or community basis - in other words, it teaches nurses the skills of assessment in relation to the clinical and cultural contexts concerned. This should also enable nurses better to understand the behaviour of patients and their families regarding religion, dress or dietary styles, which might otherwise be construed as "weird" or "atypical" from a Western point of view; and which may only be understandable in relation to ethnic and cultural differences.

In Egypt, the bridging therapy model might be regarded by some orthodox educationalists as a European style of health care which cannot be achieved in Egypt. Currently, this education is progressing towards totality of care and a holistic approach to assessment. Graduates of the High Institute of Nursing in Cairo enrol for a four-year course in general and special care before registering for a speciality, such as a master's degree or doctorate in psychiatric nursing. In this sense, nurse education in Egypt may be regarded as further advanced than that generally available in Britain, where Project 2000 is still in its planning stage. The age of graduates from the High institute of Nursing is normally 22 years or more. This is an optimal age for training in the principles of the FIA,

and for beginning to take responsibility for therapeutic planning, intervention and evaluation.

Current Egyptian curricula of nurse education emphasise the importance of links between service and community: yet this objective can never be achieved solely on a conceptual level. Unless nursing students are exposed to the practical contexts and situations involved in assessing community needs, monitoring available resources and devising means for delivery and improvement of the services, it is extremely doubtful that the concept of holistic care will ever be fully understood. In this sense, bridging therapy, with its associated use of the FIA, may provide a vehicle for the introduction of a new dimension in curriculum development and practical training for Egyptian psychiatric nurses.

6.5.3. Organisational Implications

Bridging therapy possesses useful potential for improving some organisational aspects of the psychiatric nursing services, both in Sheffield and in Cairo. Thus the existing system in Sheffield produces a gap in the service between hospital- and community-based nursing care. Bridging therapy originated as an attempt to produce a model of care which could help overcome this gap and facilitate continuity of care. Within it, hospital-based nurses are encouraged to pursue follow-up duties with their discharged patients for approximately three months. During this period, it is anticipated that the patients will either regain complete independence and be discharged from the follow-up phase; or will be referred to a CPN by a process of gradual introduction during the later stages of the follow-up phase.

Recent personal communications with members of nursing staff in Ward

56, Sheffield Northern General Hospital, and in an experimental psychiatric nursing unit in St Pancras Hospital, London, reveal the recent adoption of the philosophy of bridging therapy by a number of staff nurses, who - with management approval - are currently implementing analogous therapy on a trial basis.

In the Egyptian context, bridging therapy will provide Cairo planners with an empirical model of care which has been tested cross-culturally with some interesting and potentially productive outcomes. Bridging therapy thus contributes a new, potentially effective psychiatric nursing model for consideration by health planners who find great difficulty in obtaining resources to implement examples of health care provided by the developed countries of the Western world. Bridging therapy accepts the limitations imposed by material resources in the Egyptian community; but highlights other rich human resources which, when used effectively, are of equal importance for successful psychiatric nursing care.

A further organisational potential of bridging therapy lies in the tendency of health planners, both in Britain and Egypt, to economise on the services to mentally ill patients. Bridging therapy was not an economical programme in this sense; and does not support policies which emphasise economic outcomes irrespective of the actual needs of patients and their families. It does, however, encourage health planners to visualise the potential long-term effectiveness of such a service: and to accept the alternative cost involved in further trials.

Finally, bridging therapy examines a possible strategy for transferring models of nursing care and psychotherapeutic approaches between two cultures. It demonstrates the similarities and differences of the two

cultures in relation to effective measurement of health outcomes in the context of psychiatric nursing care. In Egypt, close family relationships provide a good social example for care of the elderly and weak members of society. Conversely, in Britain, the establishment of different types of rehabilitation centres; the "open-door" policy; and the community psychiatric nursing services, all offer very good examples to the Egyptian authorities of various means by which they can help to hasten the recovery process; and, at the same time, reduce the frequently intolerable burden experienced by many Egyptian families in caring for their sick relative.

6.5.4 Research Implications

The present study of bridging therapy is an example of evaluation research: undoubtedly a difficult method, especially for use in connection with an issue as diverse as psychiatric nursing. The model used for the current study - i.e. the "methodological mix" design - demonstrates to some extent the potential effectiveness of employing a combined, quantitative and qualitative method. Ideally, evaluation research would be best conducted using a rigorous, classical experimental design. By contrast, the present study used a quasi-experimental design within the context of action research.

This method demonstrates to researchers interested in evaluation research a strategy by means of which a researcher can go some way towards meeting the canons both of scientific and naturalistic investigation. Despite the limitations of such a design, the richness of the obtained data may be seen as a reasonable justification for employing this type of "mixed" design. There can be no doubt that the tailoring of research designs to meet the specific requirements of the study context is

becoming an increasingly acceptable notion in modern social science.

In the earlier section entitled "Limitations of the Study", various actual and potential limitations were discussed with the aim of helping to produce further refinements and improvements in future research. The positive implication of such limitations would therefore be their function as "warning signals" for other researchers who may choose to follow a similar line of research to that initiated in this study. At the time of writing, these considerations are especially relevant to the work of nurse researchers in St Pancras Hospital, London, where a twelve-bedded unit has now been established to examine the philosophy of "continuity of care" delivered by the same nurse-keyworker in both hospital- and community-based contexts.

The original, apparently straightforward research question addressed by this study - that concerning the effects of improving the links between hospital- and community-based psychiatric nursing care - rapidly developed into an extremely complex set of sub-problems related (A) to the effectiveness of bridging therapy; (B) to the development of a necessary and valid assessment instrument (the BAI); and (C) to the examination of the cross-cultural implications of bridging therapy in the British and Egyptian contexts.

It is hoped that, as a result of this preliminary work, future research in this area can afford to be somewhat less complex in character; as the empirical outcomes of each of these three aspects of the present study will help to pave the way for future work. In particular, there will be no need for future researchers to face the complex problems associated with developing an appropriate assessment instrument from its absolute

beginning stages through to workability in the contexts of the study. This is perhaps especially important for those researchers who would wish to embark on further "refining" studies of the BAI in relation to cross-cultural interpretations of data obtained by its means.

6.6 Conclusion

This study of bridging therapy has been an attempt to produce empirical data concerning three related issues:

(A) Potential Patient Benefits:

The research hypothesis was that patients in acute admission wards would benefit more from a therapeutic programme tailored to their individual needs and displaying continuity of care both in hospital-based and subsequent community treatment contexts, than from currently available standard nursing care. Such a therapeutic programme was considered to provide a model of comprehensive nursing care, employing different resources, both in hospital and community, to help patients and their families regain the ability to lead independent lives, or to receive adequate nursing support, as circumstances indicated. Such a programme was to be specifically organised by the nurse-keyworker, who would be properly trained in the use of an eclectic approach to therapeutic intervention called the Flexible Integrative Approach (FIA), employing principles from different schools of psychotherapy and nursing process in accordance with situational needs.

(B) Related Assessment:

Effectiveness of the above therapeutic programme needed to be measured, or otherwise appropriately assessed, using a combination of psychometric measures - i.e. the EPI; the GHQ; and the BAI - and

qualitative case studies to illustrate each patient's recovery status both statistically, and situationally, in terms of phenomenological interpretations of the meaning of these changes in his or her life situation. In order to accomplish this, the development of a new psychometric instrument - the BAI - became indispensably necessary, since no completely appropriate measure of patient health status existed at the outset of the study.

(C) Cross-Cultural Implications:

Cross-cultural implementation of bridging therapy has also been of considerable importance within the study. For this purpose, two extremely different cultural settings were chosen. These were Britain and Egypt, representatives respectively of the developed and developing world. The importance of the cross-cultural study hinged on two purposes:

- (i) introduction to the Egyptian context of a relatively new concept - that of community psychiatric nursing care;
- (ii) development of an effective procedure for transferring and "translating" related concepts of health care from their Western origins to Egypt.

During the progress of the study, it became clear that widespread introduction was too complex to be achieved at the present stage of service development: nor could the efforts of one researcher alone establish a new model of service. The economic, political and organisational situations which encourage planners to seek less costly alternatives; social-psychological issues, such as the stigma of mental illness; and lack of human resources, especially in the Cairo context, where no trained and qualified nurses are currently available to assume

this role, all militate against too rapid or hasty attempts at introduction.

Despite material constraints in both contexts, patients both in Sheffield and Cairo showed remarkable improvement, both during and after the hospitalisation phase. Though not reaching significance over control groups, patients in both experimental groups achieved higher recovery status than those in the respective control groups. In this situation, the smallness of the samples may have "masked" statistical significance, which may become obvious with larger samples or with pooled data from successive small-scale studies. There are also indications that further studies of the BAI, employing a rather more extended ordinal scale - say, to six points - may help to reduce "ceiling" effects and rater anxiety regarding central tendency of scores; and produce subsequent, more sensitive versions of the BAI₃₀ for use in future therapeutic studies.

Finally, this study of bridging therapy and its concomitant theoretical and practical problems has been a most useful learning exercise for the researcher; enabling her to acquire considerable knowledge and skills, especially in the areas of communication with patients and staff in two extremely different cultural contexts; in assessment of patient needs and related development of therapeutic programmes using the techniques of the FIA; in the development of a new psychometric instrument; and in the development and testing of an innovative style of research design.

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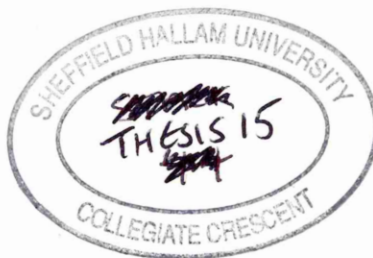
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"BRIDGING" THERAPY IN HOSPITAL -
AND COMMUNITY-BASED PSYCHIATRIC NURSING CARE:
A COMPARATIVE STUDY

by

NELLY AHMED MAHGOUB SRN BSc(Hons) MSc

VOLUME II

Thesis submitted to the Council for National Academic
Awards in partial fulfilment of the requirements for the
degree of Doctor of Philosophy

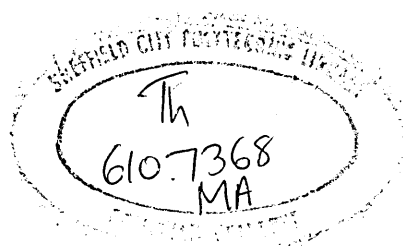
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May 1988



APPENDICES

VOLUME (2)	APPENDICES	Page
Appendix 1	Day Hospital Psychiatric Unit, Northern General Hospital	A1
Appendix 2	Eysenck Personality Inventory	A7
Appendix 3	General Health Questionnaire	A11
Appendix 4	BAI - Draft for use with Pilot Samples	A15
Appendix 5	BAI Recovery Index	A21
Appendix 6	Scoring Criteria for BAI	A57
Appendix 7	BAI - General Assessment Sheet	A80
Appendix 8	Membership of BAI Working Group	A81
Appendix 9	BAI - Draft for use with Main Samples	A82
Appendix 10	BAI Draft Manual - Modified Version I	A88
Appendix 11	BAI Draft Manual - Modified Version II	A114
Appendix 12	BAI Assessment Form	A125
Appendix 13	Arabic Version of the GHQ	A133
Appendix 14	Arabic Version of the EPQ	A135
Appendix 15	GHQ Summary Table - Sheffield Sample	A139
Appendix 16	BAI Summary Table - Sheffield Sample 30	A140
Appendix 17	EPI Summary Table - Sheffield Sample	A141
Appendix 18	GHQ Summary Table - Cairo Sample	A142
Appendix 19	BAI Summary Table - Cairo Sample 30	A143
Appendix 20	EPQ Summary Table - Cairo Sample	A144
	<u>Brief Case Studies</u>	
Appendix 21	Ronald Black	A145
Appendix 22	Rahmy Fahad	A154
Appendix 23	Victoria Carr	A162
Appendix 24	Angela Whitehead	A169
Appendix 25	Sadek Abed-El-Hamid	A181
Appendix 26	Nadia El-Gamale	A190
Appendix 27	Abdel El-Fatah	A199

APPENDIX 1

DAY HOSPITAL
PSYCHIATRIC UNIT
NORTHERN GENERAL HOSPITAL

Introduction

The Day Hospital is situated within the Psychiatric Unit N.G.H. is currently providing both psychotherapeutic and supportive groups for approximately 25 patients a day (this figure is expected to rise shortly due to re-allocation of Day Hospital space.)

Function

To provide a safe environment for patients to develop skills in dealing more effectively with life situations. Each patient is assessed and depending on the individuals needs and difficulties one or a combination of the following approaches is used; the provision of regular, understanding support, an opportunity to explore ones own feelings to aid self understanding and to develop new skills, and specific and direct guidance.

Treatment

Referrals :- Referrals are excepted from all Consultant teams working within the psychiatric unit. Suitability for treatment is assessed before admission and a programme of groups/activities is arranged for each individual.

As the treatment is specialised the disorders which are commonly treated include :- anxiety states, depressions, personality disorders, social and intra-personal difficulties, marital problems, acute psychotic episodes and alcohol abuse.

Groups

As most of the clinical work is done in a group setting the structure and style of these groups is influenced particularly by the group leaders and the group members.

A list of the groups specifically for the day patients follows :-

Monday a.m.

Art Group - A general art group its aim is to encourage its members to relate to others socially. This group is governed by the needs of the individuals referred and is therefore very flexible.

Feelings Group - A group which uses verbal methods to encourage expression of feelings and self disclosure, to aid self understanding, and to develop new attitudes, and ways of dealing/relating to people and situations.

Elderly Group/outing - A group of elderly patients who benefit from being able to get out into the community by way of an outing.

Monday p.m.

Community Skills Group - The group is mainly aimed at people who need help and support in finding outlets and other agencies that will help them to maintain good mental health. This group is also used for people who have difficulty in dealing with situations within the community. The group is flexible and the programme of trips visits is governed by the needs of the participants.

Tuesday a.m.

Womans Group - The aim of this group is to encourage/promote self awareness as individuals in a safe and supportive environment. To enhance self-confidence and self-esteem. Topics explored are sexuality, relationships, roles, feelings, emotions and human rights.

Discussion Group - Mainly aimed at the elderly the group encourages its members to relate socially to others. This group is more directive and creates a supportive atmosphere for its members.

Relaxation Group - The techniques and applications of relaxation are taught aiming to help people in their daily living.

Tuesday p.m.

Baking Group - The aim of this group is to encourage its members to relate socially to others and to learn/re-learn some basic cooking skills in a small social setting.

Painting to Music - The aim of this group is to encourage its members to express discuss their feeling, problems and worries using art and music as the projective tool.

Wednesday a.m.

Discussion/ problem solving group - The aim of this group is to encourage its members to express and learn how to manage their problems. The group looks at different types of problems (Practical, emotional, behavioural) and teaches skills to help solve them.

Project Group - This group uses art/craft and is aimed at helping people work together in a group situation it also encourages its members to relate socially to others.

Wednesday p.m.

Relaxation - The techniques and applications of relaxation are taught aimed at helping people in their daily living.

Elderly Group - A small group to promote and enable elderly patients to gain more independence in a safe and supportive atmosphere.

Thursday a.m.

Communications group - A semi-closed group using Drama ~~warm~~-up exercises, group techniques to increase the members awareness of themselves and their interactions with other people.

Topic Group - This group is aimed at helping its members to learn leisure skills lessening feelings of isolation. The group encourages its members to relate and support each other and to take an active interest in what is available in the community.

Thursday p.m.

Activity Group - This group is aimed at encouraging members to look at their lives and what they can do about the areas they wish to change.

This group is governed by the needs of its members and a flexible programme of sports activities, visits, and other community based activities are used.

Art Projection - This group uses art in a projective way as a means of expression and communication, in a supportive and safe environment exploring self-awareness, conflicts and relationships.

Friday a.m.

Relaxation- The techniques and applications of relaxation are taught aiming to help people in their daily living.

Elderly Discussion Group - This group is aimed at the elderly patients and gives them the opportunity to discuss events, problems and anxieties they may have.

Friday p.m.

Social Group - This group is mainly aimed at the elderly patient and helps to increase their awareness of their own sense of fun and enjoyment.

These are the main groups available to Day Patients, other groups (listed below) are also available but the numbers of patients that can be referred is limited, because these groups are available to the inpatient population as well.

Woodwork (Daily a.m. & p.m.) The aim of woodwork is to assess the patients work confidence, concentration, ability and social interaction skills.

Domestic Training/Assessment - This group gives a complete Domestic Assessment and any training that might be required.

Dance Therapy (Monday p.m.) - The four main aims of this group are
1. Release tension. 2. Experience working in a non-verbal group

Dance Therapy Cont.

3. Create bodily self-awareness and explore inhibitions.
4. Create the environment for the sharing of fun and enjoyment

Drink Problem Group (Mondays and Fridays p.m.) The aim of this group is to support and encourage new coping skills for people with a drink problem.

Assertiveness Training - A closed group to provide the facility for learning assertiveness and confidence in day to day situations.

Psychodrama (Tuesday P.M.) A closed group that involves acting situations of emotional significance to develop insight or resolve conflicts, particularly those of personal relationships.

Social Skills - A semi closed group to help people learn/re-learn social skill.

Individual work is also undertaken as and when it is thought appropriate and staff are available.

The programme of activities is always under review and notification of any changes will be made.

F. Robinson,
Charge Nurse.
Aug. 85.

Day	1st Session 9.30-10.30	2nd Session 11.00-12.15	3rd Session 14.00-15.15
MONDAY	Keep Fit Yoga/Relaxation Craft Quiz Ward 51 Group Pottery Woodwork	Newspaper Discussion Elderly Discussion Home Economics Meditation Pottery Woodwork Craft Relaxation Ward 56 Group therapy	Dance therapy Craft Baking Drink Problem Topic Group Collage Pottery Woodwork Pre Work group Beauty therapy Domestic training
TUESDAY	Keep Fit/Relaxation Yoga/Relaxation Craft Elderly Games Ward 53 Group Pottery Woodwork Manicurist Domestic Assessment	Social Skills Assertiveness Group Painting Group Craft Discussion Group Art Projection Pottery Woodwork Manicurist Drama Newspaper Discussion Psychotherapeutic Group	Psycho-Drama Art Projection Magazine Group Baking Quiz Music & Chat Discussion Group Pottery Woodwork Craft Community Skills
WEDNESDAY	Keep Fit/Relaxation Yoga/Relaxation Newspaper Discussion Craft Quiz Group Discussion Painting to Music Pottery Woodwork Communications Group Beauty therapy Outing(Mini-bus) Domestic Assessment	Music Group Keep Fit(Elderly) Stress management Craft Communications group Dieticians group Pottery Woodwork Relaxation(Elderly) Beauty therapy Outing(Mini-bus)	Social Skills Activity group Baking A.A. group Pottery Woodwork Group therapy Beauty therapy Art projection
THURSDAY	Communications group Yoga/Relaxation Activity group Craft Social Skills Pottery Woodwork Meditation Domestic Training	Communications Group Yoga/Relaxation Activity group Domestic Training Quiz Art Appreciation Art Projection Pottery Woodwork	Country Dancing Typing/Office Skill Baking Communications Pottery Woodwork Elderly Games Interaction Group Art Projection
FRIDAY	Keep Fit/Relaxation Relaxation Activity Group Craft Pottery Woodwork Domestic Assessment	Drama(Elderly) Relaxation Craft Womans group Mans Group Discussion group Relaxation (Elderly) Pottery Woodwork Domestic Assessment	Craft Baking Discussion Group Drink Problem Values & Ideas Art Projection Pottery Woodwork Social Skills

EYSENCK PERSONALITY INVENTORY

by H. J. Eysenck and Sybil B. G. Eysenck

PERSONALITY QUESTIONNAIRE

FORM A

NAME..... AGE.....

OCCUPATION..... SEX.....

N=

☐

E=

☐

L=

☐

Instructions

Here are some questions regarding the way you behave, feel and act. After each question is a space for answering "YES" or "NO".

Try to decide whether "YES" or "NO" represents your usual way of acting or feeling. Then put a cross in the circle under the column headed "YES" or "NO". Work quickly, and don't spend too much time over any question; we want your first reaction, not a long-drawn out thought process. The whole questionnaire shouldn't take more than a few minutes. Be sure not to omit any questions.

Now turn the page over and go ahead. Work quickly, and remember to answer every question. There are no right or wrong answers, and this isn't a test of intelligence or ability, but simply a measure of the way you behave.



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FORM A

	YES	NO
1. Do you often long for excitement?	<input type="radio"/>	<input type="radio"/>
2. Do you often need understanding friends to cheer you up?	<input type="radio"/>	<input type="radio"/>
3. Are you usually carefree?	<input type="radio"/>	<input type="radio"/>
4. Do you find it very hard to take no for an answer?	<input type="radio"/>	<input type="radio"/>
5. Do you stop and think things over before doing anything?	<input type="radio"/>	<input type="radio"/>
6. If you say you will do something do you always keep your promise, no matter how inconvenient it might be to do so?	<input type="radio"/>	<input type="radio"/>
7. Does your mood often go up and down?	<input type="radio"/>	<input type="radio"/>
8. Do you generally do and say things quickly without stopping to think?	<input type="radio"/>	<input type="radio"/>
9. Do you ever feel "just miserable" for no good reason?	<input type="radio"/>	<input type="radio"/>
10. Would you do almost anything for a dare?	<input type="radio"/>	<input type="radio"/>
11. Do you suddenly feel shy when you want to talk to an attractive stranger?	<input type="radio"/>	<input type="radio"/>
12. Once in a while do you lose your temper and get angry?	<input type="radio"/>	<input type="radio"/>
13. Do you often do things on the spur of the moment?	<input type="radio"/>	<input type="radio"/>
14. Do you often worry about things you should not have done or said?	<input type="radio"/>	<input type="radio"/>
15. Generally, do you prefer reading to meeting people?	<input type="radio"/>	<input type="radio"/>
16. Are your feelings rather easily hurt?	<input type="radio"/>	<input type="radio"/>
17. Do you like going out a lot?	<input type="radio"/>	<input type="radio"/>
18. Do you occasionally have thoughts and ideas that you would not like other people to know about?	<input type="radio"/>	<input type="radio"/>
19. Are you sometimes bubbling over with energy and sometimes very sluggish?	<input type="radio"/>	<input type="radio"/>
20. Do you prefer to have few but special friends?	<input type="radio"/>	<input type="radio"/>
21. Do you daydream a lot?	<input type="radio"/>	<input type="radio"/>
22. When people shout at you, do you shout back?	<input type="radio"/>	<input type="radio"/>
23. Are you often troubled about feelings of guilt?	<input type="radio"/>	<input type="radio"/>
24. Are all your habits good and desirable ones?	<input type="radio"/>	<input type="radio"/>
25. Can you usually let yourself go and enjoy yourself a lot at a lively party?	<input type="radio"/>	<input type="radio"/>
26. Would you call yourself tense or "highly-strung"?	<input type="radio"/>	<input type="radio"/>
27. Do other people think of you as being very lively?	<input type="radio"/>	<input type="radio"/>

28. After you have done something important, do you often come away feeling you could have done better? ☐ ☐
29. Are you mostly quiet when you are with other people? ☐ ☐
30. Do you sometimes gossip? ☐ ☐
31. Do ideas run through your head so that you cannot sleep? ☐ ☐
32. If there is something you want to know about, would you rather look it up in a book than talk to someone about it? ☐ ☐
33. Do you get palpitations or thumping in your heart? ☐ ☐
34. Do you like the kind of work that you need to pay close attention to? ☐ ☐
35. Do you get attacks of shaking or trembling? ☐ ☐
36. Would you always declare *everything* at the customs, even if you knew that you could never be found out? ☐ ☐
37. Do you hate being with a crowd who play jokes on one another? ☐ ☐
38. Are you an Irritable person? ☐ ☐
39. Do you like doing things in which you have to act quickly? ☐ ☐
40. Do you worry about awful things that might happen? ☐ ☐
41. Are you slow and unhurried in the way you move? ☐ ☐
42. Have you ever been late for an appointment or work? ☐ ☐
43. Do you have many nightmares? ☐ ☐
44. Do you like talking to people so much that you never miss a chance of talking to a stranger? ☐ ☐
45. Are you troubled by aches and pains? ☐ ☐
46. Would you be very unhappy if you could not see lots of people most of the time? ☐ ☐
47. Would you call yourself a nervous person? ☐ ☐
48. Of all the people you know, are there some whom you definitely do not like? ☐ ☐
49. Would you say that you were fairly self-confident? ☐ ☐
50. Are you easily hurt when people find fault with you or your work? ☐ ☐
51. Do you find it hard to really enjoy yourself at a lively party? ☐ ☐
52. Are you troubled with feelings of inferiority? ☐ ☐
53. Can you easily get some life into a rather dull party? ☐ ☐
54. Do you sometimes talk about things you know nothing about? ☐ ☐
55. Do you worry about your health? ☐ ☐
56. Do you like playing pranks on others? ☐ ☐
57. Do you suffer from sleeplessness? ☐ ☐

PLEASE CHECK TO SEE THAT YOU HAVE ANSWERED ALL THE QUESTIONS

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GENERAL HEALTH QUESTIONNAIRE

GHQ-60

Please read this carefully:

We should like to know if you have had any medical complaints, and how your health has been in general, *over the past few weeks*. Please answer ALL the questions on the following pages simply by underlining the answer which you think most nearly applies to you. Remember that we want to know about present and recent complaints, not those that you had in the past.

It is important that you try to answer ALL the questions.

Thank you very much for your co-operation.

HAVE YOU RECENTLY:

1 — been feeling perfectly well and in good health?	Better than usual	Same as usual	Worse than usual	Much worse than usual
2 — been feeling in need of a good tonic?	Not at all	No more than usual	Rather more than usual	Much more than usual
3 — been feeling run down and out of sorts?	Not at all	No more than usual	Rather more than usual	Much more than usual
4 — felt that you are ill?	Not at all	No more than usual	Rather more than usual	Much more than usual
5 — been getting any pains in your head?	Not at all	No more than usual	Rather more than usual	Much more than usual
6 — been getting a feeling of tightness or pressure in your head?	Not at all	No more than usual	Rather more than usual	Much more than usual
7 — been able to concentrate on whatever you're doing?	Better than usual	Same as usual	Less than usual	Much less than usual
8 — been afraid that you were going to collapse in a public place?	Not at all	No more than usual	Rather more than usual	Much more than usual
9 — been having hot or cold spells?	Not at all	No more than usual	Rather more than usual	Much more than usual
10 — been perspiring (sweating) a lot?	Not at all	No more than usual	Rather more than usual	Much more than usual
11 — found yourself waking early and unable to get back to sleep?	Not at all	No more than usual	Rather more than usual	Much more than usual
12 — been getting up feeling your sleep hasn't refreshed you?	Not at all	No more than usual	Rather more than usual	Much more than usual
13 — been feeling too tired and exhausted even to eat?	Not at all	No more than usual	Rather more than usual	Much more than usual

PLEASE TURN OVER

HAVE YOU RECENTLY:

14 — lost much sleep over worry?	Not at all	No more than usual	Rather more than usual	Much more than usual
15 — been feeling mentally alert and wide awake?	Better than usual	Same as usual	Less alert than usual	Much less alert
16 — been feeling full of energy?	Better than usual	Same as usual	Less energy than usual	Much less energetic
17 — had difficulty in getting off to sleep?	Not at all	No more than usual	Rather more than usual	Much more than usual
18 — had difficulty in staying asleep once you are off?	Not at all	No more than usual	Rather more than usual	Much more than usual
19 — been having frightening or unpleasant dreams?	Not at all	No more than usual	Rather more than usual	Much more than usual
20 — been having restless, disturbed nights?	Not at all	No more than usual	Rather more than usual	Much more than usual
21 — been managing to keep yourself busy and occupied?	More so than usual	Same as usual	Rather less than usual	Much less than usual
22 — been taking longer over the things you do?	Quicker than usual	Same as usual	Longer than usual	Much longer than usual
23 — tended to lose interest in your ordinary activities?	Not at all	No more than usual	Rather more than usual	Much more than usual
24 — been losing interest in your personal appearance?	Not at all	No more than usual	Rather more than usual	Much more than usual
25 — been taking less trouble with your clothes?	More trouble than usual	About same as usual	Less trouble than usual	Much less trouble
26 — been getting out of the house as much as usual?	More than usual	Same as usual	Less than usual	Much less than usual
27 — been managing as well as most people would in your shoes?	Better than most	About the same	Rather less well	Much less well
28 — felt on the whole you were doing things well?	Better than usual	About the same	Less well than usual	Much less well
29 — been late getting to work, or getting started on your housework?	Not at all	No later than usual	Rather later than usual	Much later than usual
30 — been satisfied with the way you've carried out your task?	More satisfied	About same as usual	Less satisfied than usual	Much less satisfied
31 — been able to feel warmth and affection for those near to you?	Better than usual	About same as usual	Less well than usual	Much less well
32 — been finding it easy to get on with other people?	Better than usual	About same as usual	Less well than usual	Much less well
33 — spent much time chatting with people?	More time than usual	About same as usual	Less than usual	Much less than usual

GO ON TO THE NEXT PAGE

HAVE YOU RECENTLY:

34	— kept feeling afraid to say anything to people in case you made a fool of yourself?	Not at all	No more than usual	Rather more than usual	Much more than usual
35	— felt that you are playing a useful part in things?	More so than usual	Same as usual	Less useful than usual	Much less useful
36	— felt capable of making decisions about things?	More so than usual	Same as usual	Less so than usual	Much less capable
37	— felt you're just not able to make a start on anything?	Not at all	No more than usual	Rather more than usual	Much more than usual
38	— felt yourself dreading everything that you have to do?	Not at all	No more than usual	Rather more than usual	Much more than usual
39	— felt constantly under strain?	Not at all	No more than usual	Rather more than usual	Much more than usual
40	— felt you couldn't overcome your difficulties?	Not at all	No more than usual	Rather more than usual	Much more than usual
41	— been finding life a struggle all the time?	Not at all	No more than usual	Rather more than usual	Much more than usual
42	— been able to enjoy your normal day-to-day activities?	More so than usual	Same as usual	Less so than usual	Much less than usual
43	— been taking things hard?	Not at all	No more than usual	Rather more than usual	Much more than usual
44	— been getting edgy and bad-tempered?	Not at all	No more than usual	Rather more than usual	Much more than usual
45	— been getting scared or panicky for no good reason?	Not at all	No more than usual	Rather more than usual	Much more than usual
46	— been able to face up to your problems?	More so than usual	Same as usual	Less able than usual	Much less able
47	— found everything getting on top of you?	Not at all	No more than usual	Rather more than usual	Much more than usual
48	— had the feeling that people were looking at you?	Not at all	No more than usual	Rather more than usual	Much more than usual
49	— been feeling unhappy and depressed?	Not at all	No more than usual	Rather more than usual	Much more than usual
50	— been losing confidence in yourself?	Not at all	No more than usual	Rather more than usual	Much more than usual
51	— been thinking of yourself as a worthless person?	Not at all	No more than usual	Rather more than usual	Much more than usual
52	— felt that life is entirely hopeless?	Not at all	No more than usual	Rather more than usual	Much more than usual
53	— been feeling hopeful about your own future?	More so than usual	About same as usual	Less so than usual	Much less hopeful

PLEASE TURN OVER

HAVE YOU RECENTLY:

54 — been feeling reasonably happy, all things considered?	More so than usual	About same as usual	Less so than usual	Much less than usual
55 — been feeling nervous and strung-up all the time?	Not at all	No more than usual	Rather more than usual	Much more than usual
56 — felt that life isn't worth living?	Not at all	No more than usual	Rather more than usual	Much more than usual
57 — thought of the possibility that you might make away with yourself?	Definitely not	I don't think so	Has crossed my mind	Definitely have
58 — found at times you couldn't do anything because your nerves were too bad?	Not at all	No more than usual	Rather more than usual	Much more than usual
59 — found yourself wishing you were dead and away from it all?	Not at all	No more than usual	Rather more than usual	Much more than usual
60 — found that the idea of taking your own life kept coming into your mind?	Definitely not	I don't think so	Has crossed my mind	Definitely has

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APPENDIX 4

SHEFFIELD CITY POLYTECHNIC
DEPARTMENT OF HEALTH STUDIES
FACULTY OF EDUCATION, HEALTH AND WELFARE

THE BEHAVIOURAL ADJUSTMENT INVENTORY
(BAI)

DRAFT FOR USE WITH PILOT SAMPLES

DETAILS

BAI Number: Example copy No 28

Name:

Age: Sex:

Occupation:

Diagnosis:

Hosp/Comm:

Health Authority:

Town:

NB Please keep this inventory confidential. Do not allow it to be photocopied or otherwise reproduced in any way, either in its blank or completed form. When completed, please return immediately to Dr Val Reed, Department of Health Studies

THE BEHAVIOURAL ADJUSTMENT INVENTORY

RATIONALE

The Behavioural Adjustment Inventory (BAI) is an empirically-based instrument for the assessment of recovery status in anxious, depressed and other psychoneurotic patients. In its construction, eighteen senior psychiatric nurses possessing as a group an aggregate qualified experience of 201.5 years (mean individual qualified experience 11.2 years) (*) were requested to identify a set of observable behaviours which they would associate with unequivocal recovery from the behavioural and adjustmental problems associated with anxiety, depression and other psychoneuroses.

METHOD

A patient's current observable behaviour should be considered in the light of each statement. If the patient is unequivocally able to perform the behaviour, then 'Yes' should be circled. If he/she is not able to perform the behaviour, or if there is any doubt, then 'No' should be circled.

SECTION A: COMMUNICATION AND SOCIAL SKILLS

During communication situations, the patient:

1	Displays appropriate, mobile facial expressions	Y	N
2	Makes/maintains eye contact for reasonable periods	Y	N
3	Body/head is oriented towards other person(s)	Y	N
4	Maintains relaxed, normal body posture	Y	N
5	Displays suitable expressive gestures	Y	N
6	Maintains 'comfortable' social distance from other person(s)	Y	N
7	Tone of voice is varied and expressive	Y	N
8	Voice is well-modulated - neither too loud nor too soft	Y	N
9	Speaks at suitable speed - neither too fast nor too slow	Y	N
10	Initiates conversation when socially appropriate	Y	N
11	Controls amount of speech to socially 'correct' levels	Y	N
12	Speaks with normal fluency	Y	N
13	Waits for his/her 'turn' to speak	Y	N
14	Listens carefully to others during conversation	Y	N
15	Gives a full answer in reply to a question	Y	N
16	Converses about a variety of subjects	Y	N
17	Talks about himself/herself only when appropriate	Y	N
18	Discusses personal feelings without awkwardness or undue restraint	Y	N

* Psychiatric nurses taking part in the construction of the BAI work in the following health authorities: Barnsley (1); East Birmingham (1); Bradford (1); Central Notts (2); Darlington (1); Hull (1); N Lincs (1); S Lincs (1); Nottingham (1); Rotherham (2); Sheffield (3); Scunthorpe (1); Singapore (1); Wakefield (1)

19	Expresses personal opinions from time to time	Y	N
20	Disagrees with others occasionally	Y	N
21	Argues without undue aggression	Y	N
22	Makes requests from time to time	Y	N
23	Will 'speak up' for himself/herself when necessary	Y	N
24	Appears clean and reasonably tidy most times	Y	N
25	Takes a reasonably active part in social interaction	Y	N
26	Keeps his/her emotions reasonably under control	Y	N
27	Stays on good terms with others usually	Y	N
28	Can communicate easily with others	Y	N
29	Is outgoing and supportive to others most times	Y	N
30	Can 'lose' or 'give in' gracefully when occasion demands	Y	N

SECTION B: INSIGHT

31	Is aware when he/she is feeling specially tense/nervous/uptight/on edge	Y	N
32	Can describe these feelings and their meanings for him/her clearly	Y	N
33	Has a definite personal strategy for relieving tension/anxiety	Y	N
34	Admits to feelings of annoyance/irritation/frustration/anger	Y	N
35	Can identify the kind of thoughts which 'trigger off' such feelings	Y	N
36	Can identify the kind of event(s) which 'trigger off' such feelings	Y	N
37	Has a definite personal strategy for preventing/relieving irritation/anger	Y	N
38	Can identify thoughts which are personally relaxing and pleasurable	Y	N
39	Can identify activities which are personally relaxing and pleasurable	Y	N
40	Can describe the kind of person(s) whom he/she distrusts/dislikes	Y	N
41	Can describe the kind of person(s) whom he/she trusts/likes/feels secure with	Y	N
42	Can identify the kind of event(s) which make him/her feel insecure/afraid	Y	N
43	Can identify the kind of event(s) which make him/her feel secure/happy	Y	N
44	Can describe the events leading to his/her present course of treatment	Y	N
45	Can recognise whether his/her own actions were responsible for these events	Y	N
46	Makes a realistic appraisal of his/her current behavioural/emotional problems	Y	N
47	Decides which of several problems is the most urgent and should be worked on first	Y	N

48	Can decide upon a realistic course of action in dealing with such problems	Y	N
49	Collaborates well with others in this type of problem discussion and problem-solving	Y	N
50	Has realistic expectations regarding what he/she can achieve in the short- and long-term	Y	N

SECTION C: SELF AND FAMILY CARE

51	Appears well-nourished with normal weight for height and build	Y	N
52	Is able to shop for household necessities	Y	N
53	Prepares suitable and adequate meals for himself/herself	Y	N
54	Prepares suitable and adequate meals for family	Y	N
55	Keeps to reasonably regular mealtimes during the day	Y	N
56	Has cooking skills to produce varied and attractive meals	Y	N
57	Displays acceptable table manners	Y	N
58	Clears up systematically after meals	Y	N
59	Stores foodstuffs appropriately and hygienically	Y	N
60	Washes up and puts pots away regularly	Y	N
61	Keeps adequate stocks of essential foodstuffs	Y	N
62	Is able to 'eat out' if the need arises	Y	N
63	Personal hygiene is obviously acceptable	Y	N
64	Selects own clothes appropriately according to the weather	Y	N
65	Dresses appropriately to the occasion	Y	N
66	Maintains and keeps clothes clean and in good repair	Y	N
67	Cares for clothing by putting it away, hanging it up etc	Y	N
68	Attends to details of grooming - eg hair, teeth and nails well cared for	Y	N
69	Shaves and/or trims beard regularly; or applies cosmetics with care	Y	N
70	Regularly brushes clothes and shoes	Y	N
71	Undertakes general household chores effectively	Y	N
72	Strips and makes the bed(s) regularly	Y	N
73	Keeps bed-linen regularly laundered and changed	Y	N
74	Conserves household resources (eg coal, electricity etc)	Y	N
75	Manages personal/family finances adequately	Y	N
76	Guards against common household dangers	Y	N
77	Takes simple precautions for personal and family health	Y	N
78	Seeks medical help when required	Y	N
79	Goes about own neighbourhood regularly	Y	N
80	Uses personal or public transport without difficulty	Y	N

SECTION D: WORK AND RECREATIONAL ACTIVITIES

81	Attends work regularly and punctually except in justifiable circumstances.	Y	N
82	Shows concentration whilst carrying out tasks	Y	N
83	Quality of work meets with the desired standard/expectation	Y	N
84	Works well as a member of a team	Y	N
85	Is a good timekeeper generally	Y	N
86	Adapts well to his/her working environment	Y	N
87	Shows keenness/interest in his/her own work	Y	N
88	Demonstrates appropriate initiative at work	Y	N
89	Has few and unavoidable sickness absences	Y	N
90	Remembers and carries out instructions without difficulty	Y	N
91	Has readily identifiable hobbies/interests	Y	N
92	Clearly enjoys his/her leisure pursuits	Y	N
93	Is able to relax and unwind during leisure pursuits	Y	N
94	Has friend(s) with whom he/she can pursue leisure activities	Y	N
95	Pursues a varied selection of leisure activities	Y	N
96	Shows interest in group activities	Y	N
97	Shows initiative in seeking out and programming individual activities	Y	N
98	Behaves in a relaxed and friendly way towards both sexes during social activities	Y	N
99	Displays normal interest in potential sexual partners	Y	N
100	Demonstrates a realistic awareness of his/her own strengths/limitations in selecting suitable leisure activities	Y	N

END OF BEHAVIOURAL ADJUSTMENT INVENTORY

TEXTS CONSULTED

Members of the Working Group extend their grateful acknowledgements to the authors of the following texts, which provided a valuable source of guidance during the construction of the Behavioural Adjustment Inventory:

1. GOLDSTEIN, SPRAFKIN and GERSHAW (1976)
The Social Skill Rating Scale
2. KIRKLEES METROPOLITAN COUNCIL (1982)
Mirfield Day Centre: Assessment Profile
Huddersfield: Directorate of Social Services
3. SMITH L (1980)
A nursing history and data sheet (Paper No 7 of the series 'Psychiatry under Review') London: Nursing Times 24.4.80 pp749-754
4. WHELAN E and SPEAKE B (1979)
A Scale for Assessing Coping Skills London: Capewell Publications
5. WHELAN E and SCHLESINGER H (1979)
A Work Skills Rating Scale London: Capewell Publications

APPENDIX 5

SHEFFIELD CITY POLYTECHNIC
DEPARTMENT OF HEALTH STUDIES
FACULTY OF EDUCATION, HEALTH AND WELFARE

BAI RECOVERY INDEX
DETAILED DESCRIPTIVE MANUAL FOR THE BAI 100 ITEM

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BAI RECOVERY INDEX

GENERAL TO ALL CATEGORIES: Categories of 'Severe', 'Moderate' and 'Recovered'

SEVERE: Represented by positions (1) and (2) on the recovery index. At this level the behavioural problem is causing severe disruption of/interference with the patient's daily relationships and activities.

MODERATE: Represented by position (3) on the recovery index. At this level the behavioural problem is somewhat improved, but still causing moderate disruption of/interference with the patient's daily relationships and activities.

RECOVERED: Represented by positions (4) and (5) on the recovery index. At this level the patient's behaviour is improved to the extent that the behavioural problem is no longer causing disruption of/interference with the patient's daily relationships and activities.

BAI RECOVERY INDEX

SECTION A

ITEM ONE

1. Habitually displays a fixed or excessively mobile inappropriate facial expression
2. Displays occasional changes, or control of excessive changes, of facial expression lasting for a few seconds only, with appropriate encouragement
3. Displays spontaneous mobile facial expressions of an appropriate kind on some occasions
4. Displays spontaneous and appropriate facial expressions most of the time
5. Displays appropriate, mobile facial expressions

BAI RECOVERY INDEX

SECTION A

ITEM TWO

1. Makes no eye contact with anyone at any time
2. Makes very little eye contact and only with people well known to him
3. Makes occasional eye contact with others, with appropriate encouragement
4. Makes systematic eye contact with others during a short interactive sequence of approximately five minutes
5. Makes/maintains eye contact for reasonable periods

ITEM THREE

1. Body/head remains averted all the time during social interaction
2. Directs body/head towards close friends/acquaintances for brief periods during social interactions
3. Directs body/head towards others for periods in excess of five minutes during social interaction
4. Body/head is oriented towards others during most of social interaction sequence
5. Body/head is oriented towards other person(s)

ITEM FOUR

1. Very tense and unable to stand still for long. Changes positions frequently. Facial muscles are tense. Arms and legs are held in rigid tension most times
2. Shows stress and tension in facial and limb muscles but is able to remain seated or in a continuous situation for a period of time ranging between five and fifteen minutes
3. Signs of stress and tensions are sometimes absent when busy with an interesting activity or undergoing relaxation therapy
4. Signs of stress and tension absent most of the time, only appearing when concerned with particularly upsetting or 'sensitive' areas
5. Maintains relaxed, normal body posture

ITEM FIVE

1. Expressive gestures are completely absent as part of any social interaction
2. Displays occasional, possibly inappropriate, expressive gestures
3. Displays occasional, appropriate expressive gestures
4. Displays suitable expressive gestures most of the time during social interaction, with occasional 'woodenness'
5. Displays suitable expressive gestures

ITEM SIX

1. Maintain maximal possible distance from others during social interactions, or habitually assumes a position uncomfortably close to others
2. Can be persuaded to assume a 'comfortable' social distance for brief periods during social interactions
3. Occasionally spontaneously assumes a 'comfortable' social distance from others, maintaining this for a brief period (ie less than five minutes) during social interaction
4. Spontaneously maintains a 'comfortable' social distance from others for rather longer periods
5. Maintains 'comfortable' social distance from other person(s)

ITEM SEVEN

1. Tone of voice is habitually monotonous and inexpressive
2. Tone of voice is habitually monotonous and inexpressive, with occasional hints of animation of an isolated nature
3. Conversational tone rather more animated, with increased frequency of expressive sequences during social interaction (ie three examples or more during a half-hour conversation)
4. Conversational tone usually varied and expressive with occasional lapses into monotone
5. Tone of voice is varied and expressive

ITEM EIGHT

1. Voice completely and habitually unmodulated to social requirements of interaction
2. Voice is modulated briefly only when patient's attention is brought to inappropriate loudness or softness
3. Voice is spontaneously modulated for brief periods as the patient regains insight into resultant social effects
4. Voice is well-modulated most of the time during social interaction
5. Voice is well-modulated - neither too loud nor too soft

ITEM NINE

1. Does not speak at all, or speaks unintelligibly fast or with partial fragmented utterances not 'hanging together' for communication purposes
2. Can be persuaded to slow down/speed up his/her delivery for brief periods on occasions
3. Speaks at suitable speed more frequently during social interactions
4. Habitually speaks at suitable speed, with occasional lapses due to excitement or stress
5. Speaks at suitable speed - neither too fast nor too slow

ITEM TEN

1. Does not initiate or participate in any social conversation
2. Participates in/states that he/she participates in conversation with close friends or acquaintances
3. Occasionally initiates conversation/states that he/she occasionally initiates conversation with close friends or acquaintances
4. Participates in/states that he/she participates in conversations with a rather wider circle of acquaintances
5. Initiates conversation when socially appropriate

ITEM ELEVEN

1. Quite unable to control amount of speech to socially 'correct' levels
2. Able with therapist support/help to control amount of speech to socially 'correct' level for relatively brief periods (ie five minutes or so)
3. Able with therapist support/help to control amount of speech to socially 'correct' level for an appreciably longer period (ie ten minutes or so) before losing such control
4. Now exerts appreciable control over amount of speech for whole interaction sequences of half-an-hour or so
5. Controls his/her amount of speech to socially 'correct' levels

ITEM TWELVE

1. Initiates and maintains speech only with great difficulty due to stress impediment(s)
2. Stress impediment very noticeable even when conversing with close friends or acquaintances
3. Stress impediment very noticeable when conversing with relative strangers
4. Speaks most of the time/states that he/she speaks most of the time with normal fluency and with only occasional 'crises'
5. Speaks with normal fluency

ITEM THIRTEEN

1. Tends to speak all the time without consideration for others' 'turn', even when requested to give way
2. Will sometimes wait for his/her 'turn' when requested to do so
3. Will sometimes wait for his/her 'turn' without a request to do so
4. Waits for his/her 'turn' most of the time with occasional lapses due to stress or excitement
5. Waits for his/her 'turn' to speak

ITEM FOURTEEN

1. Never appears to listen to others during conversation
2. Occasionally pays brief attention to others during conversation when reminded to do so
3. Makes a spontaneous effort to attend to others during conversation, succeeding for brief periods (ie less than five minutes in an interactive sequence of half-an-hour)
4. Listens carefully to others without reminders and for rather longer periods
5. Listens carefully to others during conversation

ITEM FIFTEEN

1. Does not answer any question
2. Gives only very short, incomplete answers to questions
3. Able to give rather fuller answers to questions with appropriate encouragement
4. Answers questions fully on most occasions but with occasional uncommunicative or taciturn episodes
5. Gives a full answer in reply to a question

ITEM SIXTEEN

1. Is unable to shift his/her conversation from one central obsessive topic, OR converses about multiple unconnected topics all the time
2. Is able to discuss, or control discussion to deal with, a limited number of topics when encouraged to do so
3. Converses about a reasonable variety of topics when encouraged to do so
4. Converses spontaneously about a variety of topics with only occasional reversions to obsessive topics OR recourse to multiple unconnected topics
5. Converses about a variety of subjects

ITEM SEVENTEEN

1. Talks about himself/herself all the time
2. Talks about himself/herself most of the time
3. Periodically talks about himself/herself for long periods
4. Is able on most occasions to restrain talk about himself/herself to socially appropriate levels with advice and encouragement
5. Talks about himself/herself only when appropriate

(NB Information for scoring this item may come both from psychiatric interview and from others involved - the patient, relatives, nurses and so on)

ITEM EIGHTEEN

1. Unable/refuses to speak about his/her feelings to anyone
2. Speaks with the therapist about some of his/her personal feelings but only in an awkward and restrained manner
3. Speaks with the therapist about personal feelings without undue awkwardness or restraint when supported and encouraged to do so
4. Speaks about his/her personal feelings with a few close friends/acquaintances in a small group situation
5. Is able to discuss his/her personal feelings without undue awkwardness or restraint

ITEM NINETEEN

1. Never expresses a personal opinion on any occasion
2. Will express a personal opinion very occasionally in response to encouragement, but is obviously stressed by having to do so
3. Will occasionally express his/her personal opinion without stress to a circle of close friends or acquaintances
4. Expresses his/her personal opinion from time to time in general discussion when encouraged to do so and apparently without undue stress
5. Expresses personal opinions from time to time

(NB Information for scoring this item may come from interview and from other involved - the patient, relatives, nurses and so on)

ITEM TWENTY

1. Never disagrees with others on any occasion
2. Very occasionally disagrees with close friends or acquaintances or with the therapist when encouraged to do so
3. Is able very occasionally to express spontaneous disagreement with close friends or acquaintances or with the therapist
4. Is able to express spontaneous disagreement very occasionally in a rather wider social group
5. Disagrees with others occasionally

ITEM TWENTY-ONE

1. Very aggressive or vulnerable on most occasions and may be violent during arguments
2. Argues in an aggressive, vulnerable manner even when advised not to do so, but is never physically violent
3. Tries with some success to control his/her aggression during arguments with the help of appropriate reminders and support
4. Is able to argue/discuss most of the time without resort to aggression and with only slight supervision
5. Argues without undue aggression

ITEM TWENTY-TWO

1. Never makes any requests at all
2. Makes very occasional requests only when encouraged and only in the presence of close friends or acquaintances
3. Makes occasional spontaneous requests from those close to him
4. Makes very occasional requests from others in a rather wider social context when encouraged to do so
5. Makes requests from time to time

(NB Information for scoring this item may come both from interview and/or from others involved - the patient, relatives, nurses and so on)

ITEM TWENTY-THREE

1. Completely unable to 'speak up' for himself/herself or to express personal views or wishes on any occasion
2. Nods or shakes head to accept/reject ideas but does not actively disagree
3. Will 'speak up' for himself/herself occasionally but only with support and encouragement
4. Will 'speak up' for himself/herself with people of his/her own age group spontaneously on occasions
5. Will 'speak up' for himself/herself when necessary

ITEM TWENTY-FOUR

1. Pays no attention at all to his/her personal cleanliness or appearance
2. Sometimes pays attention to his/her personal cleanliness or appearance but only with encouragement or supervision
3. Stays clean and tidy most of the time with help, encouragement or supervision
4. Appears clean and tidy most times with a minimum of support and supervision
5. Appears clean and reasonably tidy most times

ITEM TWENTY-FIVE

1. Never participates in social interaction of any kind
2. Occasionally participates in social interaction with support and encouragement, for brief periods
3. Occasionally spontaneously participates in social interaction for brief periods (ie five minutes)
4. Spontaneously participates in social interaction for rather longer periods (ie twenty minutes or so)
5. Takes a reasonably active part in social interaction

ITEM TWENTY-SIX

1. Displays little control over his/her emotions, readily becoming tearful/ anxious/angry during discussion of his/her problems: OR displays 'over-control' of his/her feelings and will not admit to them
2. Sometimes able to control emotions, OR to release some of his/her emotions with appropriate encouragement and support
3. Exerts reasonable control over emotional display; OR can express his/her emotions more freely on most occasions with encouragement and support
4. Exerts reasonable control of emotions OR displays ability to release emotions appropriately on most occasions spontaneously
5. Keeps his/her emotions reasonably under control

ITEM TWENTY-SEVEN

1. Unable to stay on good terms with others, staying isolated or readily becoming the focus of 'trouble'
2. Finds great difficulty in staying on good terms with others; can maintain these only for relatively short periods without 'trouble'
3. Able to stay on good terms with others for short interactive sequences (half-an-hour) with encouragement
4. Able to stay on good terms spontaneously and for rather longer periods
5. Stays on good terms with others usually

ITEM TWENTY-EIGHT

1. Finds great difficulty in communicating with anyone at any time
2. Is able to communicate with therapist or those close to him/her for short periods but is obviously stressed and needs much encouragement and support
3. Is able to communicate spontaneously with those close to him/her for brief periods (half-an-hour)
4. Can communicate briefly in a wider social setting with appropriate encouragement and support
5. Can communicate easily with others

ITEM TWENTY-NINE

1. Very shy, quiet and keeps himself/herself to himself/herself most of the time
2. Generally shy and quiet but can sometimes be supportive to close friends
3. Is less shy and now makes an effort to be supportive to others when appropriately encouraged
4. Makes a spontaneous effort to be outgoing and supportive to others on appropriate occasions
5. Is outgoing and supportive to others most times

ITEM THIRTY

1. Never 'gives in' gracefully when occasion demands, getting very angry, vulnerable or violent on such occasions
2. 'Gives in' generally with a bad grace, but does not become overtly vulnerable or violent
3. Can 'give in' gracefully on rare occasions with appropriate encouragement and support
4. Will sometimes 'give in' gracefully and spontaneously when occasion demands
5. Can 'lose' or 'give in' gracefully when occasion demands

ITEM THIRTY-ONE

1. Not able at any time to express any awareness of when he/she is undergoing periods of special tension
2. Is able very occasionally to identify for others the existence of a period of special tension for him/her with appropriate encouragement and support
3. Is able occasionally spontaneously to identify the existence of such a period of tension and stress
4. Is normally aware of the onset of periods of special tension and spontaneously to identify such periods
5. Is aware when he/she is feeling specially tense/nervous/uptight/on edge

ITEM THIRTY-TWO

1. Is unable to offer any clear description of how he/she is feeling during these periods
2. Can occasionally describe some of these feelings with reasonable clarity with appropriate support and encouragement
3. Is occasionally able spontaneously to describe some of these feelings with reasonable clarity
4. Can generally describe most of these feelings reasonably clearly, but with some 'blocks'
5. Can describe these feelings and their meanings for him/her clearly

ITEM THIRTY-THREE

1. Has no constructive personal strategy for relieving tension and anxiety
2. Shows awareness of the problem by attempting to develop such a personal strategy, or by seeking professional advice
3. Shows active cooperation with the therapist in developing a suitable strategy for relieving tension and anxiety
4. Shows perseverance in following the developed strategy with appropriate encouragement and support
5. Has a definite insightful and constructive personal strategy for relieving tension and anxiety

ITEM THIRTY-FOUR

1. Denies and conceals all his/her feelings of annoyance, irritation, anger and frustration, not admitting to these at any time
2. Very occasionally reveals his awareness of these feelings to therapist or close friends, with appropriate encouragement and support
3. Is able occasionally spontaneously to discuss such feelings with therapist or close friends, but no-one else
4. Occasionally admits to, and discusses such feelings in a wider social context (ie group therapy)
5. Admits to feelings of annoyance/irritation/frustration/anger

ITEM THIRTY-FIVE

1. Is completely unable to identify the kind of thoughts which initiate feelings of annoyance, frustration, anger or irritation
2. Has some awareness of these 'trigger' thoughts and is able occasionally to discuss them with therapist or close friends when appropriately supported and encouraged to do so
3. Is able spontaneously to discuss such thoughts, but with some 'blocking'
4. Has a comprehensive awareness of the type and range of such thoughts and will discuss them spontaneously during therapy with encouragement
5. Can identify the kind of thoughts which 'trigger off' such feelings

ITEM THIRTY-SIX

1. Is completely unable to identify the kind of events which initiate feelings of annoyance, frustration, anger or irritation
2. Has some awareness of these 'trigger' events and is able occasionally to discuss them with the therapist or with close friends when appropriately supported or encouraged to do so
3. Is able spontaneously to discuss such events but with some 'blocking'
4. Has a comprehensive awareness of the type and range of such events and will discuss them spontaneously during therapy with encouragement
5. Can identify the kind of event(s) which 'trigger off' such feelings

ITEM THIRTY-SEVEN

1. Has no definite insightful, constructive personal strategy for preventing/relieving irritation/anger
 2. With help and encouragement, appears able to work out such a strategy
 3. Has identified/developed such a strategy and is able to implement it with appropriate help and supervision
 4. Is able to put his/her irritation or anger-relieving strategy into practice when necessary, with minimal help or supervision
 5. Has a definite personal strategy for preventing/relieving irritation/anger
-

ITEM THIRTY-EIGHT

1. Cannot identify any thoughts which are personally relaxing and pleasurable
 2. During conversation with therapist or close friends, can be helped to identify at least one or two such pleasant ideas
 3. During conversation with therapist or close friends, will discuss one or two such ideas spontaneously from time to time
 4. Can identify and discuss such ideas appropriately within a wider social context (eg group therapy) when this is appropriate
 5. Can identify thoughts which are personally relaxing and pleasurable
-

ITEM THIRTY-NINE

1. Cannot identify any activity which is personally relaxing and pleasurable
2. During conversation with therapist or close friends can be helped to identify at least one or two such pleasant activities
3. During conversation with therapist or close friends, will discuss one or two such activities spontaneously from time to time
4. Can identify and discuss such activities appropriately within a wider social context (eg group therapy) when this is appropriate
5. Can identify activities which are personally relaxing and pleasurable

ITEM FORTY

1. Is completely unable to identify the personal characteristics of individuals whom he/she dislikes
2. During conversation with therapist or close friends, can be helped to identify at least one or two characteristics which cause him/her to feel 'threatened'
3. In this small intimate group situation, will spontaneously express such dislikes in appropriate context from time to time
4. Can identify and discuss personal characteristics which he/she sees as 'threatening' in the wider group context when encouraged to do so
5. Can describe the kind of person(s) whom he/she distrusts/dislikes

ITEM FORTY-ONE

1. Is completely unable to identify the personal characteristics of individuals whom he/she trusts, likes or feels secure with
2. During conversation with therapist or close friends, can be helped to identify at least one or two characteristics of a trusted friend or acquaintance
3. Again in this small intimate group, can be helped to identify common factors among the characteristics of trusted friends
4. Can spontaneously identify and discuss such characteristics in appropriate context in group or wider social discussion
5. Can describe the kind of person(s) whom he/she trusts/likes/feels secure with

ITEM FORTY-TWO

1. Is completely unable to identify any of the events which make him/her feel insecure or afraid
2. Can identify with help at least one event which produces these feelings
3. Can identify with help more than one such event and can be helped to see the linking features of such events
4. Will spontaneously identify one or two such events during interview or group discussion
5. Can identify the kind of event(s) which make him/her feel insecure/afraid

ITEM FORTY-THREE

1. Is completely unable to identify any of the events which make him/her feel secure/happy
2. Can identify with help at least one event which produces these feelings
3. Can identify with help more than one such event and can be helped to see the linking features of such events
4. Will spontaneously identify one or two such events during interview or group discussion
5. Can identify the kind of event(s) which make him/her feel secure/happy

ITEM FORTY-FOUR

1. Is unable to describe any of the events leading up to his/her present course of treatment
2. With help, can identify and describe at least two aspects or features of the events leading up to his/her present course of treatment
3. With help, can identify and describe most of the events leading up to his/her present course of treatment
4. Can identify and describe all of the events leading up to his/her present course of treatment with only minimal prompting or help
5. Can describe the events leading to his/her present course of treatment

ITEM FORTY-FIVE

1. Has no idea that his/her actions were responsible for events leading to emotional responses and inability to cope outside the hospital
2. Is able to accept the possibility that some of his/her actions could be responsible for these events
3. Can identify certain personal actions that may have been responsible for, or instrumental in producing, these events
4. Is able with guidance and encouragement, to recognise which aspects of specific actions may have been responsible for, or instrumental in producing, these events
5. Can recognise whether his/her own actions were responsible for these events

ITEM FORTY-SIX

1. Is completely unable to make a realistic appraisal of his/her current behavioural/emotional problems
2. Can identify with help at least one such problem and give some account of how it may be affecting his/her wellbeing
3. Can identify with help more than one such problem and can be helped to see the linking features of such problems
4. Will spontaneously identify his/her main problems and begin to collaborate with insight in a strategy to help overcome them
5. Makes a realistic appraisal of his/her current behavioural/emotional problems

ITEM FORTY-SEVEN

1. Cannot decide on the relative priority or urgency of his/her problems
2. Can identify with help at least one initial problem to be tackled early in therapy
3. Identifies with help more than one 'priority' area, and actively tries to decide which problem is the more/most urgent and should be tackled first
4. Decides spontaneously which of two or more problems is the most urgent and should be worked on first
5. Decides which of several problems is the most urgent and should be worked on first

ITEM FORTY-EIGHT

1. Cannot decide upon any realistic course of action in dealing with personal problems identified as most in need of solution
2. Displays some personal initiative towards, or seeks professional help in trying to determine, a realistic course of action in dealing with such problems
3. With help and encouragement, can identify the essential features of a realistic course of action in dealing with such problems
4. With help and encouragement, decides upon, and shows some perseverance in pursuing, a realistic course of action in dealing with these problems
5. Can decide upon a realistic course of action in dealing with such problems

ITEM FORTY-NINE

1. Finds it impossible to collaborate with anyone in any type of problem discussion or problem-solving
2. Tries to collaborate with therapist or close friends in problem discussion and solution, with constant encouragement and help
3. Is beginning to collaborate with some success in such problem analysis and solution, with slightly less prompting and help
4. Collaborates actively most of the time in problem discussion and problem-solving
5. Collaborates well with others in this type of problem discussion and problem-solving

ITEM FIFTY

1. Cannot make any realistic estimate of his/her likely achievements in either short- or long-term
2. Is able with encouragement and advice to form a reasonably realistic set of short-term goals
3. Is able with encouragement and advice to form a reasonably realistic set of long-term goals, and to understand in what ways the short-term goals will contribute to their eventual achievement
4. Is able with minimal prompting to discuss the short- and long-term goals and spontaneously to modify them in the light of reappraisal
5. Has realistic expectations regarding what he/she can achieve in the short- and long-term.

ITEM FIFTY-ONE

1. Displays severe weight loss/gain with danger to health, which appears to be progressive
2. Trend to weight change is halted, with patient cooperating in personal/professional strategies to improve his/her health status
3. Displays gradual weight change and improvement in nutritional status under relatively constant supervision
4. Has regained normal body weight and is maintaining it under periodic supervision
5. Appears well-nourished, with normal weight for height and build

ITEM FIFTY-TWO

1. Is unable to do any shopping at all
2. Can shop in the presence of a therapist or a friend and with the assistance of a list of the required provisions
3. Occasionally able to shop alone with guidance, encouragement and a list of the required provisions
4. Is able to shop alone for household necessities with minimal encouragement
5. Is able to shop for household necessities

ITEM FIFTY-THREE

1. Is unable to prepare any food or drink for himself/herself
2. Can prepare simple beverages/soups with encouragement and supervision, but nothing more elaborate
3. Can prepare a meal consisting of soup, beverage, eg boiled egg, with encouragement and supervision
4. Can prepare a simple meal with the help of written instructions and with minimal supervision
5. Is able to prepare suitable and adequate meals for himself/herself

ITEM FIFTY-FOUR

1. Is unable to cope with preparing food and drink for others
 2. Can prepare simple beverages/soups for others with encouragement and supervision, but nothing more elaborate
 3. Can prepare a meal consisting of soup, beverage and, eg boiled egg, for from two to four others, with encouragement and supervision
 4. Can prepare a simple meal for from two to four others with the help of written instructions and with minimal supervision
 5. Is able to prepare suitable and adequate meals for family or for a small group of people (eg two to four others)
-

ITEM FIFTY-FIVE

1. Is unable to establish any pattern: eats completely irregularly
 2. Eats reasonably regularly with support, advice and close supervision
 3. Makes an effort to adhere to reasonably regular mealtimes with some success with minimal supervision
 4. Eats reasonably regularly most of the time
 5. Keeps to reasonably regular mealtimes during the day
-

ITEM FIFTY-SIX

1. Is completely lacking in cooking skills
2. Can cook very simple meals with full supervision
3. Can cook rather more complex meals with full supervision
4. Can cook varied meals with minimal supervision
5. Is able to cook varied and acceptable meals

ITEM FIFTY-SEVEN

1. Is completely lacking in acceptable table manners
2. Is able to display acceptable table manners with full supervision and reminders
3. Makes a spontaneous attempt to display acceptable table manners on occasions
4. Is able to display acceptable table manners most of the time with minimal prompting
5. Displays acceptable table manners

ITEM FIFTY-EIGHT

1. Never clears up after meals, OR overdoes it, taking a very long time to do so
2. Sometimes clears up after meals appropriately with full supervision
3. Usually clears up after meals appropriately with full supervision
4. Usually clears up after meals appropriately with minimal supervision
5. Clears up systematically and appropriately after meals

ITEM FIFTY-NINE

1. Never stores foodstuffs correctly, leaving them around on surfaces and inadequately protected
2. Sometimes stores foodstuffs correctly with full supervision
3. Usually stores foodstuffs correctly with full supervision
4. Usually stores foodstuffs correctly with minimal supervision
5. Stores foodstuffs appropriately and hygienically

ITEM SIXTY

1. Never washes up or puts anything away properly; OR washes up excessively and repetitively stacks pots away
2. Sometimes washes up and puts pots away appropriately and unobsessionally with full supervision
3. Usually washes up and puts pots away appropriately and unobsessionally with full supervision
4. Usually washes up and puts pots away appropriately and unobsessionally with minimal supervision
5. Washes up and puts pots away regularly

ITEM SIXTY-ONE

1. Never keeps a stock of essential foodstuffs
2. Sometimes keeps a stock of essential foodstuffs with full supervision
3. Usually keeps a stock of essential foodstuffs with full supervision
4. Usually keeps a stock of essential foodstuffs with minimal supervision
5. Keeps adequate stocks of essential foodstuffs

ITEM SIXTY-TWO

1. Is unable to 'eat out' at all
2. 'Eats out' only with difficulty - snacks only and with help and encouragement
3. Can eat a restaurant meal in company with and encouraged by therapist or friends
4. Can eat out on occasions with others or by himself/herself
5. Is able to 'eat out' if the need arises

ITEM SIXTY-THREE

1. Pays no attention at all to personal hygiene; OR overdoes personal hygiene
2. Sometimes pays slight attention to personal hygiene; OR displays some ability to control over-attention to it, with support, encouragement and close supervision
3. Pays appropriate attention to personal hygiene with support, encouragement and supervision
4. Pays spontaneous attention to essential and basic personal hygiene in an appropriate manner without supervision
5. Personal hygiene is obviously acceptable

ITEM SIXTY-FOUR

1. Displays no awareness of, and dresses inappropriately to, the weather
2. Sometimes dresses appropriately to the weather, with encouragement and support
3. Usually dresses appropriately to the weather with encouragement and support
4. Usually dresses appropriately to the weather with occasional 'lapses'
5. Selects own clothes appropriately according to the weather

ITEM SIXTY-FIVE

1. Never dresses appropriately even with support
2. Sometimes dresses appropriately with full supervision and support
3. Usually dresses appropriately with encouragement and support
4. Usually dresses appropriately to occasion, with occasional 'lapses'
5. Dresses appropriately to the occasion

ITEM SIXTY-SIX

1. Clothes are EITHER uncared-for OR over-maintained (ie excessively/obsessionally attended to)
2. Shows occasional efforts to care for/control care of his/her clothes with full encouragement and support
3. Usually maintains and cares for his/her clothes appropriately with full encouragement and support
4. Usually maintains and cares for his/her clothes appropriately, with only occasional 'lapses' or obsessional episodes
5. Maintains and keeps clothes clean and in good repair

ITEM SIXTY-SEVEN

1. Never puts clothing away or hangs it up; or is obsessively occupied with this activity to an abnormal extent
2. Sometimes puts clothing away and hangs it up, or limits his/her preoccupation with this activity, with full encouragement and support
3. Usually puts clothing away and hangs it up, or limits his/her preoccupation with this activity, with full encouragement and support
4. Usually cares for clothing appropriately and unobsessionally, with occasional 'lapses'
5. Cares for clothing by putting it away, hanging it up etc

ITEM SIXTY-EIGHT

1. Details of grooming are habitually neglected
2. Occasionally attends to details of grooming with full encouragement and support
3. Usually attends to details of grooming with full encouragement and support
4. Attends to details of grooming most of the time, with occasional 'lapses'
5. Attends to details of grooming, eg hair, teeth and nails well cared for

ITEM SIXTY-NINE

1. Beard habitually unshaven or untrimmed; or uses cosmetics haphazardly and without care
2. Occasionally shaves/trims beard or applies cosmetics with care, with full encouragement and support
3. Usually shaves/trims beard or applies cosmetics with care, with full encouragement and support
4. Usually shaves/trims beard or applies cosmetics with care, with occasional 'lapses'
5. Shaves and/or trims beard regularly; or applies cosmetics with care

ITEM SEVENTY

1. Never cleans or brushes clothes and shoes; OR cleans and brushes them obsessively all the time
2. Occasionally cleans and brushes clothes and shoes appropriately with full encouragement and support
3. Usually cleans and brushes clothes and shoes appropriately with full encouragement and support
4. Usually cleans and brushes clothes and shoes appropriately with occasional 'lapses' or obsessive episodes
5. Regularly brushes clothes and shoes

ITEM SEVENTY-ONE

1. Never carries out household chores; OR does them obsessively all the time
2. Sometimes carries out household chores appropriately, with full encouragement and support
3. Usually carries out household chores appropriately, with full encouragement and support
4. Undertakes household chores effectively, with occasional 'lapses' or obsessive episodes
5. Undertakes general household chores effectively whenever the need arises

ITEM SEVENTY-TWO

1. Never strips and makes the bed; or is obsessively fixated on this activity
2. Sometimes strips and makes the bed/makes the bed without undue repetition, with full encouragement and support
3. Usually strips and makes the bed effectively with full encouragement and support
4. Strips and makes the bed(s) regularly with occasional 'lapses'
5. Strips and makes the bed(s) regularly

ITEM SEVENTY-THREE

1. Never changes or launders the bed-linen; or does this all the time
2. Sometimes changes and launders the bed-linen (without undue repetition) with full encouragement and support
3. Usually changes and launders the bed-linen effectively with full encouragement and support
4. Keeps bed-linen regularly laundered and changed with occasional 'lapses' into inaction or obsessional repetition
5. Keeps bed-linen regularly changed and laundered

ITEM SEVENTY-FOUR

1. Shows no ability to conserve household resources
2. Occasionally conserves household resources with full encouragement and support
3. Usually conserves household resources with full encouragement and support
4. Conserves household resources with occasional 'lapses'
5. Conserves household resources (eg coal, electricity etc)

ITEM SEVENTY-FIVE

1. Is completely unable to manage personal/family finances adequately
2. Is unable to manage personal/family finances adequately during periods of illness
3. Manages personal/family finances adequately even when feeling ill, with full encouragement and support
4. Manages personal/family finances adequately with occasional 'lapses'
5. Manages personal/family finances adequately

ITEM SEVENTY-SIX

1. Never guards against common household dangers: or is obsessed with their possibility to the extent of not using household equipment
2. Occasionally guards against common household dangers/uses potentially dangerous equipment sensibly with full supervision, encouragement and support
3. Usually guards against such dangers/uses equipment sensibly with full encouragement and support
4. Guards against such dangers/uses equipment sensibly with only occasional 'lapses'
5. Guards against common household dangers

ITEM SEVENTY-SEVEN

1. Either totally neglects simple precautions for personal/family health or else overdoes them
2. Sometimes takes simple, sensible precautions for personal/family health with full support and encouragement
3. Usually takes simple, sensible precautions for personal/family health with full support and encouragement
4. Takes simple, sensible precautions for personal/family health with occasional 'lapses'
5. Takes simple precautions for personal and family health

ITEM SEVENTY-EIGHT

1. Either never seeks medical help at all, or else over-consults
2. Sometimes seeks medical help when required, or tries to limit consultation to appropriate levels, with full support and encouragement
3. Usually seeks medical help when required, or limits consultation to appropriate levels, with full support and encouragement
4. Seeks medical help/limits consultation when appropriate, with occasional 'lapses'
5. Seeks medical help when required

ITEM SEVENTY-NINE

1. Is unable to leave his/her place of residence
2. Is sometimes able to go about own neighbourhood when encouraged and accompanied by the therapist or a close friend or relative
3. Is usually able to go about own neighbourhood when encouraged and accompanied by the therapist or a close friend or relative
4. Is able to go about own neighbourhood unaccompanied with occasional 'lapses'
5. Is able to go about own neighbourhood

ITEM EIGHTY

1. Unable to use personal or public transport
2. Sometimes able to use personal or public transport with full support and encouragement
3. Usually able to use personal or public transport with full support and encouragement
4. Uses personal or public transport with occasional 'lapses' into inability to do so
5. Uses personal or public transport without difficulty

ITEM EIGHTY-ONE

1. Never goes to work even with encouragement to do so;
OR works excessively and obsessively
2. Attends work only sporadically; OR occasionally curbs obsessional working
with much encouragement
3. Attends work but is unable to maintain acceptable punctuality; OR reverts to
obsessional pattern
4. Attends work regularly, punctually and for appropriate periods most of the
time
5. Attends work regularly and punctually and appropriately except in justifiable
circumstances

(NB In case of housewives or unemployed, these criteria should be interpreted in
terms of the manner in which housework is addressed; regularity/punctuality
of attendance for therapy etc)

ITEM EIGHTY-TWO

1. Is unable to concentrate at all whilst attempting to carry out tasks
2. Makes some effort to concentrate whilst attempting to carry out tasks with
appropriate encouragement and support
3. Is able to concentrate for appreciable periods (ie for half-an-hour or so) when
carrying out tasks with appropriate encouragement and support
4. Displays spontaneous concentration when carrying out tasks for most of the
time, with occasional 'lapses'
5. Shows concentration whilst carrying out tasks

ITEM EIGHTY-THREE

1. Quality of work consistently falls below acceptable standard
2. Makes some effort to achieve acceptable standard with full encouragement
and support
3. Occasionally achieves acceptable standard of work with full encouragement
and support
4. Spontaneously achieves an acceptable quality of work most of the time, with
occasional 'lapses'
5. Quality of work meets with the desired standard/expectation

(NB In case of housewives or unemployed, these criteria should be interpreted in
terms of the manner in which housework is addressed; standard of work
produced in therapy etc)

ITEM EIGHTY-FOUR

1. Is totally unable to work as a member of a team
2. Makes an effort to work as a member of a team but experiences difficulties and failures in this respect
3. Is able to function successfully in some aspects of teamwork
4. Works successfully as a team member for most of the time with help and encouragement
5. Works well as a member of a team

(NB Data sources include, eg, behaviour in day hospital or various reports on the patient. In the case of the housewife at home, the 'team context' is that of the family; and criteria should be interpreted as such)

ITEM EIGHTY-FIVE

1. Is habitually unable to keep time
2. Makes an effort to keep time with full encouragement and support
3. Successfully keeps time for appreciable periods (eg one week) with full encouragement and support
4. Spontaneously keeps time on most occasions, with occasional 'lapses'
5. Is a good timekeeper generally

(NB In the case of housewives or the unemployed, these criteria should be interpreted in terms of the manner in which housework is addressed; punctuality in therapy etc)

ITEM EIGHTY-SIX

1. Shows no ability to adapt to his/her working environment
2. Tries to adapt to his/her working environment with help and encouragement for appreciable periods (eg one month)
3. Adapts successfully to his/her working environment with help and encouragement for appreciable periods (eg one month)
4. Adapts to his/her working environment spontaneously and successfully for most of the time
5. Adapts well to his/her working environment

ITEM EIGHTY-SEVEN

1. Is habitually apathetic towards/uninterested in his/her work
2. Shows occasional, relatively fleeting, interest in his/her work with full encouragement and support
3. Displays an appreciable level of interest in, and involvement with, his/her work for appreciable periods (ie half-an-hour) with full encouragement and support
4. Shows spontaneous interest in his/her work most of the time, with occasional 'lapses'
5. Shows keenness/interest in his/her work

(NB In the case of housewives or the unemployed, these criteria should be interpreted in terms of the manner in which housework is addressed; level of interest in therapy etc)

ITEM EIGHTY-EIGHT

1. Shows no initiative at work at any time
2. Shows occasional initiative with full encouragement and support
3. Is able to sustain an appreciable level of initiative for, eg a day or so, with full encouragement and support
4. Shows spontaneous initiative at work most of the time, with occasional 'lapses'
5. Demonstrates appropriate initiative at work

(NB In the case of housewives or the unemployed, these criteria should be interpreted in terms of the manner in which housework is addressed; initiative shown in therapy etc)

ITEM EIGHTY-NINE

1. Has many sickness absences without offering acceptable reasons (ie on a weekly basis)
2. Has an appreciable number of 'avoidable' sickness absences (ie on a monthly basis)
3. Most of his/her sickness absences are unavoidable
4. Attends work regularly most of the time, with only occasional 'lapses'
5. Has few unavoidable sickness absences

(NB In the case of housewives or the unemployed, these criteria should be interpreted in terms of the manner in which housework is addressed; sickness absence from therapy etc)

ITEM NINETY

1. Has great difficulty in remembering and carrying out instructions
2. Can remember and carry out frequently-repeated instructions, with full encouragement and support
3. Can remember and carry out frequently repeated instructions with only minimal support
4. Can spontaneously remember and carry out instructions most of the time, with occasional 'lapses'
5. Remembers and carries out instructions without difficulty

ITEM NINETY-ONE

1. Has no identifiable hobbies or interests
2. Shows relatively short-lived interest in some activity(ies), with full encouragement
3. Shows interest in self-selected activity(ies) for an appreciable period (ie half-an-hour) with full encouragement
4. Displays spontaneous interest in self-selected activity(ies); and pursues them with minimal encouragement
5. Has readily identifiable hobbies/interests

ITEM NINETY-TWO

1. Is unable to enjoy any leisure pursuits
2. Takes a very transient pleasure in leisure pursuits when these have been arranged for him/her
3. Takes more obvious and sustained pleasure in such prearranged pursuits
4. Enjoys spontaneously selected and personally arranged leisure pursuits, with occasional 'lapses'
5. Clearly enjoys his/her leisure pursuits

ITEM NINETY-THREE

1. Very tense and unable to relax at all during leisure pursuits
2. Able to relax for a short period (eg ten minutes) during leisure activities, with reassurance and support
3. Able to relax for longer periods (eg half-an-hour) during leisure activities, with reassurance and support
4. Able to relax spontaneously during leisure activities on most occasions, with occasional 'lapses'
5. Is able to relax and unwind during leisure pursuits

ITEM NINETY-FOUR

1. Has no friends and lives a completely solitary life
2. Has one or two acquaintances but cannot pursue leisure activities with them
3. Has one or two acquaintances with whom he/she may occasionally pursue leisure activities
4. Has one friend with whom he/she may occasionally pursue leisure activities
5. Has friend(s) with whom he/she can pursue leisure activities on a more regular basis

ITEM NINETY-FIVE

1. Displays no motivation to pursue leisure activities; OR overdoes it to the neglect of other things
2. Shows occasional enthusiasm for leisure activities, with full encouragement
3. Spontaneously pursues one type of leisure activity with appropriate involvement most of the time
4. Spontaneously pursues more than one leisure activity with appropriate involvement most of the time
5. Pursues a varied selection of leisure activities

ITEM NINETY-SIX

1. Displays no interest in any group activity despite full encouragement
2. Participates slightly in group activities only with full encouragement
3. Participates voluntarily in group activities with small groups of individuals well-known to him/her
4. Is starting spontaneously to join in most group activities
5. Shows interest in group activities

ITEM NINETY-SEVEN

1. Never shows any initiative in seeking out or programming individual activities
2. Shows very occasional initiative in seeking out or programming individual activities, with full support
3. Is beginning to show more initiative in seeking out or programming individual activities most of the time, with full support
4. Shows spontaneous initiative in seeking out or programming individual activities most of the time, with occasional 'lapses'
5. Shows initiative in seeking out and programming individual activities

ITEM NINETY-EIGHT

1. Is very tense and 'wound up' in the presence of the opposite sex during social activities; and appears unable to relate to them in any way
2. Is less tense in the presence of the opposite sex during social activities; but definitely still feels 'uncomfortable' in their presence
3. Is able to relax in the presence of familiar members of the opposite sex; but is still 'uncomfortable' in the presence of strangers of the opposite sex
4. Relaxes spontaneously in the presence of members of the opposite sex most of the time, but with occasional 'lapses'
5. Behaves in a relaxed and friendly way towards both sexes during social activities

ITEM NINETY-NINE

1. Displays complete lack of interest in potential sexual partners
2. Displays a brief and passive interest only (ie only when approached)
3. Displays a brief active interest (ie will occasionally 'make the first move')
4. Displays a spontaneous active interest by following-up relationships on more than one occasion
5. Displays a normal interest in potential sexual partners

ITEM ONE HUNDRED

1. Appears totally unaware of his/her strengths and weaknesses in selecting suitable leisure activities
2. Is able occasionally to appreciate his/her strengths and weaknesses when these are explained to him/her
3. Is usually able to appreciate his/her strengths and weaknesses when these are explained; and to direct his/her choice accordingly
4. Shows spontaneous awareness of his/her strengths and weaknesses; and selects leisure activities accordingly most of the time, with occasional 'lapses'
5. Demonstrates a realistic awareness of his/her own strengths and limitations in selecting suitable leisure activities

APPENDIX 6

SHEFFIELD CITY POLYTECHNIC
DEPARTMENT OF HEALTH STUDIES
FACULTY OF EDUCATION, HEALTH AND WELFARE

SCORING CRITERIA FOR THE BEHAVIOURAL ADJUSTMENT INVENTORY (BAI):

A DRAFT MANUAL

EXAMPLE COPY NO

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SCORING CRITERIA FOR THE BEHAVIOURAL ADJUSTMENT INVENTORY: A DRAFT MANUAL

NATURE OF THE BEHAVIOURAL ADJUSTMENT INVENTORY (BAI)

The BAI is an empirically-based instrument for the assessment of general recovery status in anxious, mildly depressed and other psychoneurotic patients. The inventory provides a checklist of behaviour regarded as either (A) providing evidence of preservation of normal performance levels; or (B) providing unequivocal evidence of recovery from major behavioural/adjustmental problems associated with anxiety, mild depression or other psychoneuroses. The skill performance areas selected for assessment include:

- A Communication and social skills
- B Insight
- C Self and family care
- D Work and recreative activities

in which areas the BAI is intended to function as an empirical aid to assessment; and in particular to the construction and monitoring of an appropriate psychiatric nursing care plan for the benefit of patients in either hospital or community contexts of care.

The intention is that the BAI should be completed by the assessor (referred to throughout the manual as A) in respect of the subject (referred to throughout the manual as S) as early as possible in the assessment/treatment situation. When completed the BAI will thus provide a useful therapeutic indicator by identifying area(s) upon which the nurse/therapist may wish to concentrate during subsequent therapy sessions with S, ie any of the inventory items which A has found it impossible to check unequivocally by circling 'Y' (for 'yes'), bearing in mind the criteria offered for successful completion of such item(s) in this manual. Having identified 'priority' items for the individual patient from among the items circled 'N' (for 'no'), the nurse/therapist will no doubt wish to analyse such item(s) in greater depth, in order that an individually-structured 'scale of recovery' (based on strictly relevant items and closely geared to the life situation and special nursing/therapeutic needs of that individual patient) may be constructed, again employing behavioural criteria, this time related internally to progress in each chosen item; and presented (eg) in the form of a five-point semantic scale.

MODE OF CONSTRUCTION

Twenty-two senior psychiatric nurses possessing as a group an aggregate qualified experience of 227.5 years (mean individual qualified experience 10.34 years) (*) were requested to identify a set of behaviours which were observable or verifiable by other means which they associated with unequivocal recovery from the main behavioural/adjustmental problems associated with anxiety, mild depression and other psychoneuroses. Detailed membership of this Working Group is given in Annexe B to this manual.

* Psychiatric nurses taking part in the construction of the BAI work in the following health authorities: Barnsley (1); East Birmingham (1); Bradford (1); Central Notts (2); Darlington (1); Hull (2); N Lincs (2); S Lincs (1); N Derbyshire (1); Nottingham (2); Rotherham (2); Sheffield (3); Scunthorpe (1); Singapore (1); Wakefield (1)

From an early stage it became apparent that the behaviour so identified could be grouped logically in four major 'skill areas':

Skill Area	Number of Items
A Communication and Social Skills	30
B Insight	20
C Self and Family Care	30
D Work and Recreative Activities	<u>20</u>
Total BAI items	100

Table 1: Grouping of Assessment Items in the BAI

Each item is cast in the form of a definite statement, expressing the behaviour which the Working Group considers as providing suitable evidence of definite normality/recovery in the sub-skill concerned.

METHOD OF ADMINISTRATION

1. The BAI should be administered by an experienced psychiatric nurse/assessor as early as possible in the assessment/treatment situation; and completed as near to the point of referral as possible.
2. Items may be assessed in any order; and an experienced assessor will find it possible to assess several items on the same occasion(s).
3. Before circling any item, the assessor should carefully check the patient's observed/reported behaviour against the exact criterion offered in this manual. IT MUST NOT BE ASSUMED THAT ANY BEHAVIOUR MENTIONED IN THE ITEMS OF THE BAI IS SELF-EVIDENT. The only satisfactory method of achieving objective assessment is TO ADHERE STRICTLY TO THE CRITERIA OFFERED.
4. During the actual assessment session(s), the assessor should keep a copy of the BAI unobtrusively to hand as a guide to observation; but no attempt should be made obviously to complete items during the assessment period itself. Relevant items of the BAI should be completed as soon as possible after the assessment session, and CERTAINLY NOT LEFT UNTIL THE FOLLOWING DAY, except in the case of those items for which more than one assessment session is required. In the case of these latter items, the BAI should be completed NO LATER THAN THE DAY ON WHICH THE FINAL ASSESSMENT SESSION TAKES PLACE.
5. In the case of each item, a patient's current observable/reported behaviour should be considered in the light of the criterion offered in this manual.
6. If the patient is able unequivocally to perform the behaviour, then 'Y' (for 'yes') should be circled on the BAI.
7. If he/she is NOT able to perform the behaviour, then 'N' (for 'no') should be circled on the BAI.
8. If there is any DOUBT, then the item should be left UNCOMPLETED until further assessmental check(s) have resolved the issue one way or the other.

SCORING CRITERIA FOR THE BEHAVIOURAL ADJUSTMENT INVENTORY (BAI):
A DRAFT MANUAL

SECTION A: COMMUNICATION AND SOCIAL SKILLS

1. Displays appropriate, mobile facial expressions

Assessment situation: Any conversational situation(s) with a minimum aggregate duration of half-an-hour

Criterion: S produces attentive/smiling/frowning/ other change or variety of facial reactions which are concurrent and predominantly consistent with, the subjects discussed.

2. Makes/maintains eye-contact for reasonable periods

Assessment situation: Any conversational situation(s) with a minimum aggregate duration of half-an-hour, and which involves S and A in direct face-to-face interaction

Criterion: A looks directly at S and elicits definite eye-contact on at least three occasions. Each eye-contact should equal or exceed a slow count of one (ie the time taken to say 'one thousand' to oneself) but should not be embarrassingly protracted by S.

3. Body/head is oriented towards other person(s)

Assessment situation: Any conversational situation(s) with a minimum aggregate duration of half-an-hour

Criterion: S keeps body turned towards speaker(s) during conversation, and turns head in direction of current speaker.

4. Maintain relaxed, normal body posture

Assessment situation: Any conversational situation(s) with a minimum aggregate duration of half-an-hour

Criterion: S reclines or sits easily without any apparent tension during most of the interaction. Signs of stress (rigid sitting; tense, angular posture; repeated changes of position; gripping chair arm) should be largely or completely absent.

5. Displays suitable expressive gestures

Assessment situation: Any conversational situation(s) with a minimum aggregate duration of half-an-hour

Criterion: S uses movements of head/hands/shoulder/trunk (ie leaning backwards or forwards) which generally assist his/her communication; and which 'mesh' with/appear appropriate in the context of the verbal discourse which they accompany.

6. Maintains 'comfortable' social distance from other persons

Assessment situation: Any conversational situation(s) with a minimum aggregate duration of half-an-hour, and which involves S and A in direct face-to-face interaction

Criterion: At the start of the conversation, S spontaneously takes up a position relative to A which A feels to be socially 'comfortable' - ie neither too distant nor uncomfortably close. S should appear at ease with this relative distance throughout the course of the conversation(s).

7. Tone of voice is varied and expressive

Assessment situation: Any conversational situation(s) with a minimum aggregate duration of half-an-hour

Criterion: By tonal changes, S is able to express a variety of cognitive/emotional responses including eg amusement, sympathy, doubt, conviction, irony. Tonal communication must be cognitively/emotionally appropriate to the subject(s) of discourse. Flat, monotonous utterances should be largely absent.

8. Voice is well-modulated - neither too loud nor too soft

Assessment situation: Any conversational situation(s) with a minimum aggregate duration of half-an-hour

Criterion: S is able to sustain his/her part of the discussion at a suitable conversational level which is neither inaudible nor deafening. Episodes of shouting or inaudibility should be absent; and comfortable conversational pitch maintained throughout.

9. Speaks at suitable speed - neither too fast nor too slow

Assessment situation: Any conversational situation(s) with a minimum aggregate duration of half-an-hour

Criterion: When S speaks, A should be able comfortably to hear every word which he/she utters. A must not feel either 'stretched' to keep up with the pace of S's talk or embarrassingly 'hung up' waiting for the next word. A good, intelligible, conversational pace should be maintained throughout the interaction.

10. Initiates conversation

Assessment situation: Any conversational situation(s) with a minimum aggregate duration of half-an-hour, and which involves S and A in direct face-to-face interaction

Criterion: On at least three occasions A should leave an appropriate hiatus in the conversation. S must respond by initiating appropriate talk during the hiatus on at least two of these occasions.

11. Controls amount of speech to socially 'correct' levels

Assessment situation: Any conversational situation(s) with a minimum aggregate duration of half-an-hour

Criterion: S should make small to moderate contributions to the conversation, without seeking to monopolise the stage or 'drown out' other speakers, or to embark on lengthy monologues.

12. Speaks with normal fluency

Assessment situation: Any conversational situation(s) with a minimum aggregate duration of half-an-hour, and which involves S and A in direct face-to-face interaction

Criterion: S's speech should be, in the main, continuous, without excessive stammerings or prolonged temporal hesitations. Preliminary and intermediate 'filled pauses' and slight temporal hesitations are however acceptable.

13. Waits for his/her 'turn' to speak

Assessment situation: Any conversational situation(s) with a minimum aggregate duration of half-an-hour

Criterion: S shows no systematic tendency to butt in whilst another person is talking; although one or two manifestly accidental overlaps may be allowed.

14. Listens carefully to others during conversation

Assessment situation: Any conversational situation(s) with a minimum aggregate duration of half-an-hour

Criterion: S clearly shows by direction of eye gaze/orientation of head and/or trunk towards the speaker/alert or interested facial expression/salient reply that he/she is following the speaker with due attention.

15. Gives a full answer in reply to a question

Assessment situation: Any conversational situation(s) with a minimum aggregate duration of half-an-hour, and which involves S and A in direct face-to-face interaction

Criterion: S replies to A's questions by means of at least one appropriately constructed sentence. A number of A's questions should be of the type requiring such a response, ie one which cannot be completely answered monosyllabically or in a very few words, eg "What did you do for your holiday last year?" A must elicit at least three full responses of this type during the assessment period.

16. Converses about a variety of subjects

Assessment situation: Any conversational situation(s) with a minimum aggregate duration of half-an-hour

Criterion: S's conversation is not limited by obsessive pre-occupation with one or two topics. He/she is able to add relevant contributions to at least three topic areas raised by A in the course of a general conversation with S.

17. Talks about himself/herself only when appropriate

Assessment situation: Any conversational situation(s) with a minimum aggregate duration of half-an-hour, and which involves S and A in direct face-to-face interaction

Criterion: S is able to conduct a substantial part of his conversation without self-reference; only introducing personal issues when asked about these or when they are directly relevant to the discussion.

18. Discusses personal feelings without awkwardness or undue restraint

Assessment situation: Any conversational situation(s) with a minimum aggregate duration of half-an-hour, and which involves S and A in direct face-to-face interaction

Criterion: When asked by A about his/her personal feelings S can discuss these calmly, without becoming overly embarrassed, tongue-tied or excessively emotional.

19. Expresses personal opinions from time to time

Assessment situation: Any conversational situation(s) with a minimum aggregate duration of half-an-hour, and which involves S and A in direct face-to-face interaction

Criterion: During the conversation, S offers original ideas or contributions of his/her own to the topic under discussion on at least two occasions.

20. Disagrees with others occasionally

Assessment situation: Any conversational situation(s) with a minimum aggregate duration of half-an-hour, and which involves S and A in direct face-to-face interaction

Criterion: S expresses an alternative opinion after others have spoken, as observed by A on at least one occasion.

21. Argues without undue aggression

Assessment situation: Any interactive situation during which a conflict of opinion has naturally arisen

Criterion: S sustains his part of the argument politely and in conversational tones without resort to raised voice or non-verbal threatenings.

22. Makes requests from time to time

Assessment situation: Any interactive situation involving hospital or community staff including A

Criterion: S is observed to make a request on at least one occasion.

23. Will speak up for himself/herself when necessary

Assessment situation: Any conversational situation(s) with a minimum aggregate duration of half-an-hour, and which involves S and A in direct face-to-face interaction

Criterion: S attempts to justify himself/herself on some issue when asked to do so by A on at least one occasion. An appropriate example of a question requiring such justification is: "Why on earth did you do that?" in response to a suitable anecdote(s).

NB Alternatively S's ability to 'speak up' may be assessed in the context of any naturally occurring confrontation. At least one instance should be observed.

24. Appears clean and reasonably tidy most times

Assessment situation: Any contact with S

Criterion: S's general state of cleanliness and tidiness must be such as to make him/her acceptable by A, judging in terms of normative standards in the context concerned. This must be the case at almost every contact.

25. Takes a reasonably active part in social interaction

Assessment situation: Any contact with S in a social context

Criterion: S must make some contribution to the social interaction occurring which is judged by A to be reasonably active for him/her, bearing in mind his/her habitual behaviour and personality.

26. Keeps his/her emotions reasonably under control

Assessment situation: Any conversational situation(s) with a minimum aggregate duration of half-an-hour

Criterion: S remains calm in the situation, with no evidence of excessive and/or uncontrolled emotional lability eg temper tantrums, crying or euphoria.

27. Stays on good terms with others usually

Assessment situation: Any contact with S in a social context

Criterion: S is seen to get on well with other people, with no more than very occasional mild altercations.

28. Can communicate easily with others

Assessment situation: Any conversational situation(s) with a minimum aggregate duration of half-an-hour, and which involves S and A in direct face-to-face interaction

Criterion: S is able to communicate with A in a relaxed and expressive manner.

29. Is outgoing and supportive to others most times

Assessment situation: Any contact with S in a social context

Criterion: S's observed behaviour towards others must be calm, helpful and good-natured on most occasions.

30. Can 'lose' or 'give in' gracefully when occasion demands

Assessment situation: Social interaction involving competitive games; or a naturally occurring confrontation in which S is 'bested' by another

Criterion: S must be observed to 'give in' gracefully and good-naturedly, without undue animosity and/or aggression towards the victor. Games of cards, chess or draughts played by A with S form a convenient modus for this assessment.

SECTION B: INSIGHT

31. Is aware when he/she is feeling specially tense/nervous/uptight/on edge

Assessment situation: Any conversational situation(s) with a minimum aggregate duration of half-an-hour, and which involves S and A in direct face-to-face interaction

Criterion: In conversation with A, S is able (a) to indicate that he/she is aware of increases of tension and nervousness in himself/herself; (b) to identify periods when these increases are occurring/or likely to occur.

32. Can describe these feelings and their meanings for him/her clearly

Assessment situation: Any conversational situation(s) with a minimum aggregate duration of half-an-hour, and which involves S and A in direct face-to-face interaction

Criterion: In conversation with A, S is able to describe and illustrate his/her experiences whilst undergoing attacks of increased tension and nervousness.

33. Has a definite personal strategy for relieving tension or anxiety

Assessment situation: Any conversational situation(s) with a minimum aggregate duration of half-an-hour, and which involves S and A in direct face-to-face interaction

Criterion: In conversation with A, S is able to identify and describe a personal method for attempting to reduce personal tension and anxiety (eg gardening, listening to music, going for a walk).

34. Admits to feelings of annoyance/irritation/frustration/anger

Assessment situation: Any conversational situation(s) with a minimum aggregate duration of half-an-hour, and which involves S and A in direct face-to-face interaction

Criterion: In conversation with A, S is able to recognise that he/she does experience such feelings in common with all of us.

35. Can identify the kind of thoughts which 'trigger off' such feelings

Assessment situation: Any conversational situation(s) with a minimum aggregate duration of half-an-hour, and which involves S and A in direct face-to-face interaction

Criterion: In conversation with A, S can clearly identify the major internal factors producing annoyance/irritation/frustration/anger.

36. Can identify the kind of events which 'trigger off' such feelings

Assessment situation: Any conversational situation(s) with a minimum aggregate duration of half-an-hour, and which involves S and A in direct face-to-face interaction

Criterion: In conversation with A, S can clearly identify the major external factors producing annoyance/irritation/frustration/anger.

37. Has a definite personal strategy for preventing/relieving irritation/anger

Assessment situation: Any conversational situation(s) with a minimum aggregate duration of half-an-hour, and which involves S and A in direct face-to-face interaction

Criterion: In conversation with A, S is able to identify and describe a personal method for attempting to reduce feelings of annoyance/irritation/frustration/anger (eg vigorous exercise, a brisk walk or run, telephoning or talking with a friend, going to the pictures).

38. Can identify thoughts which are personally relaxing or pleasurable

Assessment situation: Any conversational situation(s) with a minimum aggregate duration of half-an-hour, and which involves S and A in direct face-to-face interaction

Criterion: In conversation with A, S is able to identify and describe mental images which in his/her case have a definitely calming and relaxing effect whenever they are 'conjured up' (eg a sea or landscape, music, the image of a specific person or object, some lines of poetry or prose). At least two such thoughts must be identified.

39. Can identify activities which are personally relaxing or pleasurable

Assessment situation: Any conversational situation(s) with a minimum aggregate duration of half-an-hour, and which involves S and A in direct face-to-face interaction

Criterion: In conversation with A, S is able to identify and describe personal activities which in his/her case have a definitely calming and relaxing effect whenever they are undertaken (eg going for a walk, visiting an art gallery, attending a concert, painting, playing a game etc). The activities identified should be of a relatively constructive type, and not potentially harmful to self/others. At least two such activities must be identified.

40. Can describe the kind of person(s) whom he/she distrusts/dislikes

Assessment situation: Any conversational situation(s) with a minimum aggregate duration of half-an-hour, and which involves S and A in direct face-to-face interaction

Criterion: In conversation with A, S is able to describe some of the main physical and psychological attributes (at least two of each) which he/she particularly dislikes in other individuals and which lead to feelings of distrust or unease in their presence. The objective is to ascertain whether or not S is cognitively aware of the causes of such distrust or uneasiness.

41. Can describe the kind of person(s) whom he/she trusts/likes/feels secure with

Assessment situation: Any conversational situation(s) with a minimum aggregate duration of half-an-hour, and which involves S and A in direct face-to-face interaction

Criterion: In conversation with A, S is able to describe some of the main physical and psychological attributes (at least two of each) which he/she particularly likes in other individuals and which lead to feelings of ease, trust and security in their presence. The objective is to ascertain whether or not S is aware cognitively of the reasons for such trust and security.

42. Can identify the kind of event(s) which make him/her feel insecure/afraid

Assessment situation: Any conversational situation(s) with a minimum aggregate duration of half-an-hour, and which involves S and A in direct face-to-face interaction

Criterion: In conversation with A, S is able to identify at least two examples of external events tending to produce fear and/or feelings of insecurity. The objective is to ascertain whether or not S is cognitively aware of the reasons for such fear and insecurity.

43. Can identify the kind of event(s) which make him/her feel secure/happy

Assessment situation: Any conversational situation(s) with a minimum aggregate duration of half-an-hour, and which involves S and A in direct face-to-face interaction

Criterion: In conversation with A, S is able to identify at least two examples of external events tending to produce feelings of happiness and/or security. The objective is to ascertain whether or not S is cognitively aware of the reasons for such happiness and security.

44. Can describe the events leading to his/her present course of treatment

Assessment situation: Any conversational situation(s) with a minimum aggregate duration of half-an-hour, and which involves S and A in direct face-to-face interaction

Criterion: In conversation with A, S is able accurately to identify the main causal links in a chain of antecedent events leading to his/her current need for treatment. The objective is to ascertain whether or not S is cognitively aware of the reasons for such treatment.

45. Can recognise whether his/her own actions were responsible for these events

Assessment situation: Any conversational situation(s) with a minimum aggregate duration of half-an-hour, and which involves S and A in direct face-to-face interaction

Criterion: In conversation with A, S is able accurately to ascribe responsibility for the events concerned insofar as this can be done.

46. Makes a realistic appraisal of his/her current behavioural/emotional problems

Assessment situation: Any conversational situation(s) with a minimum aggregate duration of half-an-hour, and which involves S and A in direct face-to-face interaction

Criterion: In conversation with A, S is able to identify and characterise his/her current major problems of this type.

47. Decides which of several problems is the most urgent and should be worked on first

Assessment situation: Any conversational situation(s) with a minimum aggregate duration of half-an-hour, and which involves S and A in direct face-to-face interaction

Criterion: In conversation with A, S is able realistically to prioritise his/her problems and to show understanding of why his/her first priority area(s) are the most urgent from a therapeutic point of view.

48. Can decide upon a realistic course of action in dealing with such problems

Assessment situation: Any conversational situation(s) with a minimum aggregate duration of half-an-hour, and which involves S and A in direct face-to-face interaction

Criterion: In conversation with A, S can recognise the logic of possible treatment options; and assess with reasonable accuracy the likelihood of his/her being able satisfactorily to cooperate in the therapy(ies) with a good chance of success.

49. Collaborates well with others in this type of problem discussion and problem-solving

Assessment situation: (A) Any discussion situation involving confidential talk between A and S; or (B) an example therapy situation.

Criterion: In (A) above, S must discuss his/her potential therapy positively with A. In (B) above, S's part of the therapeutic interaction or other type of therapy must be carried out positively and recognisably along the lines previously decided at the therapy discussion.

50. Has realistic expectations regarding what he/she can achieve in the short- and long-term

Assessment situation: Any conversational situation(s) with a minimum aggregate duration of half-an-hour, and which involves S and A in direct face-to-face interaction

Criterion: In conversation with A, S must demonstrate that his/her expectations regarding treatment outcomes and potential personal capacities are not overly ambitious either in the short- or long-term, bearing in mind his/her recent responses to treatment and his/her current recovery status.

SECTION C: SELF AND FAMILY CARE

51. Appears well-nourished, with normal weight for height and build

Assessment situation: Access to current weight record, plus any contact enabling A to obtain an impression of S's current nutritional status.

Criterion: S's weight should be within normal limits, bearing in mind height, build, sex and age. There should be no obvious signs of under- or over-nourishment, eg painful thinness or obesity, or other obvious physical signs leading A to suspect, eg vitamin deficiencies.

52. Is able to shop for household necessities

Assessment situation: The patient's home

Criterion: Picking up some household article (eg butter, sugar, tea, soap, coffee) A remarks on the brand/make, and asks S where he/she bought it. S's answer may make it obvious that he/she bought it personally. If not, then a few appropriate supplementary questions (eg Did you buy it yourself? Do you go shopping on your own? With others?) can be made to rise naturally out of the situation. It must be obvious from the reply(ies) that S bought the article(s) personally and recently.

53. Prepares suitable and adequate meals for himself/herself

Assessment situation: The patient's home

Criterion: Bringing the discussion round to food. A enquires of S: "What did you have for your (main meal) yesterday?" By suitable probe questions A should elicit (A) whether the meal was prepared by S, and (B) whether he/she would normally prepare such meals for himself/herself. The nutritional adequacy of the main meal should be assessed employing the normal criteria for a balanced diet; and bearing in mind S's age, sex, work and socio-cultural/ethnic background.

(NB If A is in doubt regarding the acceptability of the account which S gives, he/she should contrive a subsequent meal time visit to check out the adequacy or otherwise of the information given.)

54. Prepares suitable and adequate meals for family

Assessment situation: The patient's home

Criterion: As for 53, but additionally A must satisfy himself/herself regarding adequacy/suitability of the diet for other family members involved.

55. Keeps to reasonably regular meal times during the day

Assessment situation: The patient's home

Criterion: A asks S, "Do you normally eat at the same time everyday?" following this up with supplementary questions to ascertain whether the regularity/irregularity applies to all meals or to some meals.

(NB If A is in doubt regarding the acceptability of the account which S gives, he/she should contrive a subsequent meal time visit to check out the accuracy or otherwise of the information given.)

56. Has cooking skills to produce varied and attractive meals

Assessment situation: The patient's home

Criterion: Whilst ascertaining suitability and adequacy of meals, A should satisfy himself/herself regarding S's culinary skills, bearing in mind socio-cultural/ethnic factors by asking some such question as, "That sounds very nice - could you tell me how to cook it? I'd like to try it myself." If necessary, the discussion may be extended to cover a few such recipes. A must satisfy himself/herself regarding the suitability in the circumstances of (A) type and quantity of ingredients used; (B) mode of preparation; (C) potential taste and appearance of food prepared in this way.

57. Displays acceptable table manners

Assessment situation: The patient's home or hospital/day centre canteen - any context in which food or drink are consumed

Criterion: The minimal criterion would be A's observation of the manner in which S consumes liquid refreshment (eg tea, coffee, fruit juice etc). Bearing in mind socio-cultural/ethnic factors, A must satisfy himself/herself that S's behaviour is acceptable from the point of view of (A) conformity to group concerned; (B) attitude and posture at table/elsewhere; (C) absence of factors such as audible consumption; wiping nose or mouth on sleeve or other parts of clothing; exceeding 'territory'; spilling food/drink on own/other's clothing; crumbs or splashes on floor.

58. Clears up systematically after meals

Assessment situation: The patient's home

Criterion: A should satisfy himself/herself observationally that appropriate domestic tidying has occurred in living room and kitchen, bearing in mind socio-cultural/ethnic factors. A minimal criterion should be the absence of plates, cups, cutlery etc from odd, unlikely surfaces (eg sideboards, window ledges, mantelpiece, floor) in the main living area(s).

59. Stores foodstuff appropriately and hygienically

Assessment situation: The patient's home

Criterion: A should satisfy himself/herself observationally (A) that foodstuffs are stored separately from other household requirements; (B) that perishables are stored appropriately in refrigerator/cool cupboard/larder; (C) that any foodstuffs not stored away are covered or otherwise protected from dust and insects; (D) that hygienic standard of such storage areas is adequate.

60. Washes up and puts pots away regularly

Assessment situation: The patient's home

Criterion: A should satisfy himself/herself observationally that dirty crockery and cutlery have not accumulated beyond normally acceptable levels, bearing in mind socio-cultural/ethnic factors. In order to meet this criterion satisfactorily it may be necessary to visit after the main meal on at least two occasions, preferably without previously informing S. A must use his/her own judgement for this latter precaution.

61. Keeps adequate stocks of essential foodstuffs

Assessment situation: The patient's home

Criterion: A should satisfy himself/herself observationally that S's stocks of essential foodstuffs (eg bread, milk, tea/coffee, eggs, cheese, or other, bearing in mind socio-cultural/ethnic factors) are sufficient to satisfy at least the essential short term needs of S/S's family.

(NB 'Essential short term needs' are defined as those nutritional needs of S and his/her family which will probably need to be satisfied between the time of A's visit and normal shopping hours on the following day or next day of trading.)

62. Is able to 'eat out' if the need arises

Assessment situation: Day/occupation centre canteen, cafe or other public eating place

Criterion: On an appropriate occasion, A arranges to meet S in the canteen/cafe, ostensibly to save time. During the interaction A should satisfy himself/herself that S can complete the process of finding his/her way to the cafe, ordering and paying for foodstuffs, and consuming them appropriately on the premises.

63. Personal hygiene is obviously acceptable

Assessment situation: Any contact involving interaction with S

Criterion: A must satisfy himself/herself observationally that S's standards of body hygiene are such as to make him/her reasonably acceptable to his/her peer group, bearing in mind the socio-cultural/ethnic factors.

64. Selects own clothes appropriately according to the weather

Assessment situation: Any outdoor context involving interaction with S

Criterion: A must satisfy himself/herself observationally whether S has selected his/her clothing with due attention to ambient weather conditions, eg waterproof clothing and well-shod in wet weather; appropriately warm clothing in cold weather; or appropriately light clothing in warm weather.

65. Dresses appropriately to the occasion

Assessment situation: Any contact involving interaction with S

Criterion: A must satisfy himself/herself observationally that S's attire is socially appropriate - ie that his/her outfit, however formal or informal, forms a suitable ensemble, bearing in mind socio-cultural/ethnic factors.

66. Maintains and keeps clothes clean and in good repair

Assessment situation: Any contact involving interaction with S

Criterion: A must satisfy himself/herself observationally that S's clothing is clean and well-maintained. This being the case, and where there is no other obvious care-taker involved, then it may be assumed that S's acceptable appearance is the product of S's own efforts. In situations where other possibilities arise (eg where S lives with parents/spouse/brother or sister) A may ascertain by dint of tactful questioning whether S is responsible for his/her own 'turnout'.

67. Cares of clothing by putting it away, hanging it up etc

Assessment situation: The patient's home

Criterion: A must satisfy himself/herself observationally that S's clothing is neatly and appropriately stored away, ie there should be no clothes strewn about the living area(s) and the clothing S is wearing should bear evidence of such care.

68. Attends to details of grooming, eg hair, teeth and nails well cared for

Assessment situation: Any contact involving interaction with S

Criterion: The criterion for this item is self-evident

69. Shaves and/or trims beard regularly; or applies cosmetics with care

Assessment situation: Any contact involving interaction with S

Criterion: The criterion for this item is self-evident

70. Regularly brushes clothes and shoes

Assessment situation: Any social context involving interaction with S on two or more occasions

Criterion: The criteria for this item are self-evident, but must be obviously present on at least two occasions.

71. Undertakes general household chores effectively

Assessment situation: The patient's home

Criterion: A must satisfy himself/herself observationally that S regularly performs such general household tasks as dusting, sweeping, tidying, cleaning paintwork etc, to acceptable standards bearing in mind socio-cultural/ethnic factors.

(NB He/she must also be satisfied that the chores mentioned are carried out by S himself/herself rather than any other caretaker involved.)

72. Strips and makes the bed(s) regularly

Assessment situation: The patient's home

Criterion: A must satisfy himself/herself observationally that S is removing all bedclothes and re-making the bed regularly to acceptable hygienic standards bearing in mind socio-cultural/ethnic factors.

(NB This assessment will obviously require observation to be carried out on one or two successive visits to be absolutely sure that the criterion is being met. A must also satisfy himself/herself that S is indeed the person involved rather than any other caretaker.)

73. Keeps bed-linen regularly laundered and changed

Assessment situation: The patient's home

Criterion: A must satisfy himself/herself observationally on successive visits that bed-linen is changed and washed by S to suitable hygienic standards bearing in mind socio-cultural/ethnic factors.

74. Conserves household resources (eg coal, electricity etc)

Assessment situation: The patient's home

Criterion: A must satisfy himself/herself observationally that S's use of coal, electricity and other household resources is not excessively prodigal; and that he/she is keeping a regular note of the expenditure incurred by these items.

75. Manages personal/family finances adequately

Assessment situation: The patient's home

Criterion: In conversation with A, S is able to discuss the amount of his/her weekly income and expenditure, accounting correctly for the various outgoings involved, and showing insight as to where the main liabilities occur. In cases where excessive expenditure has occurred or is likely to occur, S must show awareness of this, and be able to discuss with insight the various possible economies which he/she could make in order to ensure that his/her finances are effectively controlled.

76. Guards against common household dangers

Assessment situation: The patient's home

Criterion: A must satisfy himself/herself observationally that there are no obvious household hazards (eg frayed kettle flexes, unguarded coal fires, dangerously located oil heaters, loose carpets or stair rods, excess clutter producing fire hazard etc.)

77. Takes simple precautions for personal and family health

Assessment situation: The patient's home

Criterion: A must satisfy himself/herself observationally that S takes appropriate simple hygienic precautions for the welfare of himself/herself and/or his/her family, eg by ventilating living areas, by keeping a small stock of first aid requirements, by keeping readily to hand a note of his/her GP's telephone number, or by keeping a small, well-protected supply of household specifics such as, eg, aspirin or antacid powder.

78. Seeks medical help when required

Assessment situation: The patient's home or any other confidential interview situation involving A and S in face-to-face interaction

Criterion: A asks S: 'How often do you go to see your own doctor?' and as a follow-up question, 'When was the last time that you went to see him/her?' A must be satisfied by S's answer, (A) that S is aware of the need for, and possibility of, consulting his/her doctor from time to time, and (B) that he/she has consulted his/her doctor regarding the health either of himself/herself or of his/her family, on appropriate and non-frivolous occasions, bearing in mind socio-cultural/ethnic factors.

79. Goes about own neighbourhood regularly

Assessment situation: Various, including any suitable previously-arranged local venue, eg the cafeteria situation used for assessment of item 62 in some cases

Criterion: By means of suitable observation and questioning, A must satisfy himself/herself that A can move regularly about his/her own neighbourhood in a competent and independent fashion for purposes of, eg, shopping, recreational activities, or work needs.

80. Uses personal or public transport without difficulty

Assessment situation: Any conversational context involving confidential face-to-face interaction between A and S

Criterion: A asks S, 'How do you manage to get about these days?' He/she must be satisfied by means of S's answer and by means of any incidental observational evidence which it is felt desirable to obtain, that S is able without difficulty independently to use his/her own car or public transport without undue stress and in a reasonably regular manner.

SECTION D: WORK AND RECREATIONAL ACTIVITIES

NB In cases where S is unemployed and is not attending regularly at any form of day hospital/day centre activities, it may be difficult or impossible to assess items 81 to 90 appropriately. However, where possible these data should be checked either observationally in the activity context of day hospital/day centre or verbally by seeking appropriate information from occupational therapist(s) and/or instructors in these contexts, or, where it is thought to be necessary or desirable due to S's special needs, by seeking verbal information from S's employer or supervisor.

81. Attends work regularly and punctually except in justifiable circumstances

Assessment situation: Day hospital/day centre, or S's place of work

Criterion: A must satisfy himself/herself observationally on one or two occasions that S's usual pattern of attendance is regular and punctual; or must be satisfied by means of verbal questioning that S's therapist/supervisor is satisfied by the regularity of his/her attendance.

82. Shows concentration whilst carrying out tasks

Assessment situation: Day hospital/day centre, or S's place of work

Criterion: A must satisfy himself/herself observationally that S's concentration on work/occupational activities appears to be good or satisfactory, or by verbal questioning that S's general level of concentration on the task in hand is thought to be satisfactory by his/her therapist/supervisor.

83. Quality of work meets with the desired standard/expectation

Assessment situation: Day hospital/day centre, or S's place of work

Criterion: A must satisfy himself/herself by appropriate questioning that the quality of S's work/occupational activities is considered to be appropriate by his/her therapist/supervisor in the work context.

84. Works well as a member of a team

Assessment situation: Day hospital/day centre, or S's place of work

Criterion: A must satisfy himself/herself by appropriate questioning that S's work as a team member is considered to be appropriate by his/her therapist/supervisor on the majority of occasions.

85. Is a good timekeeper generally

Assessment situation: Day hospital/day centre, or S's place of work

Criterion: A must satisfy himself/herself by appropriate questioning that S's therapist/supervisor consider him/her to be generally good at timekeeping.

(NB 'Timekeeping' in this context refers not only to time of arrival at work but also the ability to fulfil the requirements and cope with the constraints of a work schedule throughout the period during which S is actually involved in the therapy/work situation.)

86. Adapts well to his/her working environment

Assessment situation: Day hospital/day centre, or S's place of work

Criterion: A must satisfy himself/herself by appropriate questioning that S is considered by his/her therapist/work supervisor to be able to adapt well to the constraints of the working environment, even when this involves periodic slight variations or alterations in venue or work routine(s).

87. Shows keenness/interest in his/her work

Assessment situation: Day hospital/day centre, or S's place of work

Criterion: A must satisfy himself/herself either observationally or by appropriate questioning that S appears keen and interested in his/her work, or is considered by his/her therapist/work supervisor to be appropriately interested and involved by the task in hand on most occasions.

88. Demonstrates appropriate initiative at work

Assessment situation: Day hospital/day centre, or S's place of work

Criterion: A must satisfy himself/herself by appropriate questioning that S's capability of taking appropriate initiative at work is considered to be suitable or appropriate by his/her therapist/work supervisor.

89. Has few and unavoidable sickness absences

Assessment situation: Day hospital/day centre, or S's place of work

Criterion: A must satisfy himself/herself by appropriate questioning that S's attendance is considered by his/her therapist/work supervisor to be appropriately consistent and unmarred by avoidable absences.

90. Remembers and carried out instructions without difficulty

Assessment situation: Day hospital/day centre, or S's place of work

Criterion: A must satisfy himself/herself by appropriate questioning that S's response to instructions and his/her ability to memorise these and to carry them out without undue error or stress is considered good by his/her therapist/work supervisor.

91. Has readily recognisable hobbies/interests

Assessment situation: Any conversational situation(s) with a minimum aggregate duration of half-an-hour, and which involves S and A in direct face-to-face interaction

Criterion: A must satisfy himself/herself observationally that S is suitably interested and motivated by the leisure activity(ies) concerned. This may be achieved by observations of S's pursuit of the activity(ies) concerned, or of S's responses whilst describing or explaining the activity to A, or in involving A in the activity(ies) concerned.

93. Is able to relax and unwind during leisure pursuits

Assessment situation: Day hospital, day centre, the patient's home or any other suitable context where the leisure activity(ies) under consideration may be pursued

Criterion: A must satisfy himself/herself both observationally and by appropriate questioning that S finds the activity(ies) concerned both relaxing and recreative, as evidenced by his/her freedom from manifest tension and/or anxiety during the activity(ies), and by the pleasure which he/she obviously takes in it, as well as by appropriate responses to A's questions concerning the activity(ies).

94. Has friend(s) with whom he/she can pursue leisure activities

Assessment situation: Any conversational situation(s) with a minimum aggregate duration of half-an-hour, and which involves S and A in direct face-to-face interaction

Criterion: In conversation with A, S must be able to identify friend(s), relative(s) or others with whom he/she can pursue leisure activities on a reasonably regular basis.

95. Pursues a varied selection of leisure activities

Assessment situation: Any conversational situation(s) with a minimum aggregate duration of half-an-hour, and which involves S and A in direct face-to-face interaction

Criterion: In conversation with A, S must be able to identify three varied leisure activities which he/she pursues/takes part in on a reasonably regular basis.

96. Shows interest in group activities

Assessment situation: Any conversational situation(s) with a minimum aggregate duration of half-an-hour, and which involves S and A in direct face-to-face interaction

Criterion: In conversation with A, S must demonstrate interest in at least one or two group activities forming part of the discussion (eg billiards/snooker, various competitive games such as chess/draughts, evening classes, disco or ballroom dancing). Alternatively, A must be able to observe S at various times engaged with obvious interest in at least one of these activities.

97. Shows initiative in seeking out and programming individual activities

Assessment situation: Any conversational situation(s) with a minimum aggregate duration of half-an-hour, and which involves S and A in direct face-to-face interaction

Criterion: In conversation with A, S must demonstrate that he/she pursues a varied and interesting selection of leisure activities in response to an appropriate question from A (eg 'Tell me how you've been occupying your leisure time just lately?') The activities should form a balanced programme which fits well into his/her weekly schedule.

98. Behaves in a relaxed and friendly way towards both sexes

Assessment situation: Any social context involving mixed group activities (eg group therapy, mealtimes, dances, club activities, concerts)

Criterion: A must satisfy himself/herself observationally that S's behaviour during such group activities is relaxed and free from any obvious tensions or anxieties, irrespective of the sexes involved.

99. Displays normal interest in potential sexual partners

Assessment situation: Any social context involving mixed group activities (eg group therapy, mealtimes, dances, club activities, concerts)

Criterion: A must satisfy himself/herself observationally regarding S's normal interest in sexual matters and in potential sexual partners, as illustrated by his/her orienting behaviour towards such partners, by discussion of such issues in conversation, and by manifest attempts to make himself/herself attractive in their presence. Some degree of supportive data may be obtained by asking S such questions as, 'Have you got a boyfriend/girlfriend at the moment?' and by assessing the congruence of his/her response in relation to his/her behaviour in the social contexts described.

100. Demonstrates a realistic awareness of his/her own strengths/weaknesses/limitations in selecting suitable leisure activities

Assessment situation: Any conversational situation(s) with a minimum aggregate duration of half-an-hour, and which involves S and A in direct face-to-face interaction

Criterion: A must be satisfied that the leisure and/or recreational activities described by S are such as he/she might be expected to pursue successfully, bearing in mind local opportunities, costs involved, S's age, sex and build, and any other factors considered to relate to the realism of his/her choices.

END OF CRITERIAL ITEMS FOR BEHAVIOURAL ADJUSTMENT INVENTORY

VR/AD 18.1.83

ANNEXE A: Representative texts consulted by members of the Working Group during construction of the Behavioural Adjustment Inventory (BAI)

1. CARNEVALE M (1976)
Mirfield Day Centre: Assessment Profile
Huddersfield: Directorate of Social Services
2. GOLDSTEIN, SPRAFKIN and GERSHAW (1976)
Skill Training for Community Living (especially the Social Skill Rating Scale from the above)
New York+ Pergamon Press
3. SMITH L (1980)
A nursing history and data sheet (Paper No 7 of the series 'Psychiatry under Review') London: Nursing Times 24.4.80 pp749-754
4. WHELAN E and SPEAKE B (1979)
A Scale for Assessing Coping Skills London: Capewell Publications
5. WHELAN E and SCHLESINGER H (1979)
A Work Skills Rating Scale London: Capewell Publications

CONFIDENTIAL

SHEFFIELD CITY POLYTECHNIC
DEPARTMENT OF HEALTH STUDIES
FACULTY OF EDUCATION, HEALTH AND WELFARE

BEHAVIOURAL ADJUSTMENT INVENTORY: GENERAL ASSESSMENT SHEET

Surname:

Forename(s):

Age: Diagnosis:

PROCEDURE: Please CIRCLE the number of each item which, in your opinion, the patient CANNOT perform to criterion.

Section A: Communication and Social Skills

1	2	3	4	5	6	7	8	9	10
11	12	13	14	15	16	17	18	19	20
21	22	23	24	25	26	27	28	29	30

Section B: Insight

31	32	33	34	35	36	37	38	39	40
41	42	43	44	45	46	47	48	49	50

Section C: Self and Family Care

51	52	53	54	55	56	57	58	59	60
61	62	63	64	65	66	67	68	69	70
71	72	73	74	75	76	77	78	79	80

Section D: Work and Recreative Activities

81	82	83	84	85	86	87	88	89	90
91	92	93	94	95	96	97	98	99	100

APPENDIX 8

MEMBERSHIP OF WORKING GROUP INVOLVED IN CONSTRUCTION OF THE BEHAVIOURAL ADJUSTMENT INVENTORY (BAI)

Name	Health Authority
<u>Section A: Communication and Social Skills</u>	
Mike CARNEVALE	Barnsley
Doug KANE	Scunthorpe
<u>Section B: Insight</u>	
Fred FEAVIOUR	Wakefield
Ken GIBSON	Bradford
Eamonn MULLIGAN	East Birmingham
<u>Section C: Self and Family Care</u>	
Claire BRAMLEY	Central Nottinghamshire
Mike CATER	Central Nottinghamshire
Robin DONY	Sheffield
Lyndon MATHIAS	North Lincolnshire
Alan PURSER	South Lincolnshire
Mike SHAW	Darlington
<u>Section D: Work and Recreative Activities</u>	
Keith CHEVERTON	Rotherham
David CURRY	Sheffield
Terry DAYKIN	Rotherham
Kim Tan HOK	Singapore
Jacky LUNN	Sheffield
Glenda OATES	Nottingham
Sue TAYLOR	Hull

APPENDIX 9

SHEFFIELD CITY POLYTECHNIC
DEPARTMENT OF HEALTH STUDIES
FACULTY OF EDUCATION, HEALTH AND WELFARE

THE BEHAVIOURAL ADJUSTMENT INVENTORY
(BAI)

DRAFT FOR USE WITH MAIN SAMPLES

DETAILS

BAI Number:

Name:

Age: Sex:

Occupation:

Diagnosis:

Hosp/Comm:

Health Authority:

NB Please keep this inventory confidential. Do not allow it to be photocopied or otherwise reproduced in any way, either in its blank or completed form. When completed, please return immediately to Dr Val Reed, Department of Health Studies

THE BEHAVIOURAL ADJUSTMENT INVENTORY

RATIONALE

The Behavioural Adjustment Inventory (BAI) is an empirically-based instrument for the assessment of recovery status in anxious, mildly depressed and other psychoneurotic patients. In its construction, twenty-two senior psychiatric nurses possessing as a group an aggregate qualified experience of 227.5 years (mean individual qualified experience 10.34 years) (*) were requested to identify a set of behaviours which were observable or verifiable by other means which they associated with unequivocal recovery from the main behavioural/adjustmental problems associated with anxiety, mild depression and other psychoneuroses.

METHOD

A patient's current observable behaviour/otherwise verifiable behaviour should be considered for each item on the inventory, in the light of the specific criterion for each behaviour provided in the accompanying manual. If the patient is unequivocally able to perform the behaviour, then 'Y' should be circled. If he/she is NOT able to perform the behaviour, then 'N' should be circled. If there is any DOUBT, then the item should be left UNCOMPLETED until further assessment(s) have decided the issue one way or the other.

SECTION A: COMMUNICATION AND SOCIAL SKILLS

1	Displays appropriate, mobile facial expressions	Y	N
2	Makes/maintains eye contact for reasonable periods	Y	N
3	Body/head is oriented towards other person(s)	Y	N
4	Maintains relaxed, normal body posture	Y	N
5	Displays suitable expressive gestures	Y	N
6	Maintains 'comfortable' social distance from other person(s)	Y	N
7	Tone of voice is varied and expressive	Y	N
8	Voice is well-modulated - neither too loud nor too soft	Y	N
9	Speaks at suitable speed - neither too fast nor too slow	Y	N
10	Initiates conversation when socially appropriate	Y	N
11	Controls amount of speech to socially 'correct' levels	Y	N
12	Speaks with normal fluency	Y	N
13	Waits for his/her 'turn' to speak	Y	N
14	Listens carefully to others during conversaton	Y	N
15	Gives a full answer in reply to a question	Y	N
16	Converses about a variety of subjects	Y	N
17	Talks about himself/herself only when appropriate	Y	N
18	Discusses personal feelings without awkwardness or undue restraint	Y	N

* Psychiatric nurses taking part in the construction of the BAI work in the following health authorities: Barnsley (1); East Birmingham (1); Bradford (1); Central Notts (2); Darlington (1); Hull (2); N Lincs (2); S Lincs (1); N Derbyshire (1); Nottingham (2); Rotherham (2); Sheffield (3); Scunthorpe (1); Singapore (1); Wakefield (1)

19	Expresses personal opinions from time to time	Y	N
20	Disagrees with others occasionally	Y	N
21	Argues without undue aggression	Y	N
22	Makes requests from time to time	Y	N
23	Will 'speak up' for himself/herself when necessary	Y	N
24	Appears clean and reasonably tidy most times	Y	N
25	Takes a reasonably active part in social interaction	Y	N
26	Keeps his/her emotions reasonably under control	Y	N
27	Stays on good terms with others usually	Y	N
28	Can communicate easily with others	Y	N
29	Is outgoing and supportive to others most times	Y	N
30	Can 'lose' or 'give in' gracefully when occasion demands	Y	N

SECTION B: INSIGHT

31	Is aware when he/she is feeling specially tense/nervous/uptight/on edge	Y	N
32	Can describe these feelings and their meanings for him/her clearly	Y	N
33	Has a definite personal strategy for relieving tension/anxiety	Y	N
34	Admits to feelings of annoyance/irritation/frustration/anger	Y	N
35	Can identify the kind of thoughts which 'trigger off' such feelings	Y	N
36	Can identify the kind of event(s) which 'trigger off' such feelings	Y	N
37	Has a definite personal strategy for preventing/relieving irritation/anger	Y	N
38	Can identify thoughts which are personally relaxing and pleasurable	Y	N
39	Can identify activities which are personally relaxing and pleasurable	Y	N
40	Can describe the kind of person(s) whom he/she distrusts/dislikes	Y	N
41	Can describe the kind of person(s) whom he/she trusts/likes/feels secure with	Y	N
42	Can identify the kind of event(s) which make him/her feel insecure/afraid	Y	N
43	Can identify the kind of event(s) which make him/her feel secure/happy	Y	N
44	Can describe the events leading to his/her present course of treatment	Y	N
45	Can recognise whether his/her own actions were responsible for these events	Y	N
46	Makes a realistic appraisal of his/her current behavioural/emotional problems	Y	N
47	Decides which of several problems is the most urgent and should be worked on first	Y	N

48	Can decide upon a realistic course of action in dealing with such problems	Y	N
49	Collaborates well with others in this type of problem discussion and problem-solving	Y	N
50	Has realistic expectations regarding what he/she can achieve in the short- and long-term	Y	N

SECTION C: SELF AND FAMILY CARE

51	Appears well-nourished with normal weight for height and build	Y	N
52	Is able to shop for household necessities	Y	N
* 53	Is able to prepare suitable and adequate meals for himself/herself	Y	N
* 54	Is able to prepare suitable and adequate meals for family or small group of people (eg 4-5)	Y	N
55	Keeps to reasonably regular mealtimes during the day	Y	N
* 56	Is able to cook varied and acceptable meals	Y	N
57	Displays acceptable table manners	Y	N
58	Clears up systematically after meals	Y	N
59	Stores foodstuffs appropriately and hygienically	Y	N
60	Washes up and puts pots away regularly	Y	N
61	Keeps adequate stocks of essential foodstuffs	Y	N
62	Is able to 'eat out' if the need arises	Y	N
63	Personal hygiene is obviously acceptable	Y	N
64	Selects own clothes appropriately according to the weather	Y	N
65	Dresses appropriately to the occasion	Y	N
66	Maintains and keeps clothes clean and in good repair	Y	N
67	Cares for clothing by putting it away, hanging it up etc	Y	N
68	Attends to details of grooming - eg hair, teeth and nails well cared for	Y	N
69	Shaves and/or trims beard regularly; or applies cosmetics with care	Y	N
70	Regularly brushes clothes and shoes	Y	N
* 71	Undertakes general household chores effectively whenever the need arises	Y	N
72	Strips and makes the bed(s) regularly	Y	N
73	Keeps bed-linen regularly laundered and changed	Y	N
74	Conserves household resources (eg coal, electricity etc)	Y	N
75	Manages personal/family finances adequately	Y	N
76	Guards against common household dangers	Y	N
77	Takes simple precautions for personal and family health	Y	N
78	Seeks medical help when required	Y	N
* 79	Is able to go about own neighbourhood	Y	N
80	Uses personal or public transport without difficulty	Y	N

SECTION D: WORK AND RECREATIONAL ACTIVITIES

81	Attends work regularly and punctually except in justifiable circumstances	Y	N
82	Shows concentration whilst carrying out tasks	Y	N
83	Quality of work meets with the desired standard/expectation	Y	N
84	Works well as a member of a team	Y	N
85	Is a good timekeeper generally	Y	N
86	Adapts well to his/her working environment	Y	N
87	Shows keenness/interest in his/her work	Y	N
88	Demonstrates appropriate initiative at work	Y	N
89	Has few and unavoidable sickness absences	Y	N
90	Remembers and carries out instructions without difficulty	Y	N
91	Has readily identifiable hobbies/interests	Y	N
92	Clearly enjoys his/her leisure pursuits	Y	N
93	Is able to relax and unwind during leisure pursuits	Y	N
94	Has friend(s) with whom he/she can pursue leisure activities	Y	N
95	Pursues a varied selection of leisure activities	Y	N
96	Shows interest in group activities	Y	N
97	Shows initiative in seeking out and programming individual activities	Y	N
98	Behaves in a relaxed and friendly way towards both sexes during social activities	Y	N
99	Displays normal interest in potential sexual partners	Y	N
100	Demonstrates a realistic awareness of his/her own strengths/limitations in selecting suitable leisure activities	Y	N

TEXTS CONSULTED DURING DRAFTING

Members of the Working Group extend their grateful acknowledgements to the authors of the following texts, which provided a valuable source of guidance during the construction of the Behavioural Adjustment Inventory:

1. CARNEVALE M (1976)
The Mirfield Day Centre: Assessment Profile
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2. GOLDSTEIN A, SPRAFKIN R and GERSHAW A (1976)
Skill Training for Community Living (especially the Social Skill Rating Scale from the above text) New York: Pergamon Press
3. SMITH L (1980)
A nursing history and data sheet (Paper No 7 of the series 'Psychiatry under Review') London: Nursing Times 24.4.80 pp749-754
4. WHELAN E and SPEAKE B (1979)
A Scale for Assessing Coping Skills London: Capewell Publications
5. WHELAN E and SCHLESINGER H (1979)
A Work Skills Rating Scale London: Capewell Publications

APPENDIX 10

SHEFFIELD CITY POLYTECHNIC
DEPARTMENT OF HEALTH STUDIES
FACULTY OF EDUCATION, HEALTH AND WELFARE

THE BEHAVIOURAL ADJUSTMENT INVENTORY (BAI)

A Draft Manual (Modified Version I)

Details

Name.....

Occupation.....

THE BEHAVIOURAL ADJUSTMENT INVENTORY (BAI): A Draft Manual (modified version)

This manual is divided into 4 sections, namely:

A	Communication and social skill	19 items
B	Insight	20 items
C	Self and family care	19 items
D	Work and recreation	8 items

The main objective of today's session is to achieve the following:

1. Develop a standardised workable instrument to identify/measure problem areas encountered by psychiatric patients in their own community in respect of the above areas.
2. A 5-point scale will be used to assess the degree of handicap in each of the identified problem areas.
3. Changes in patient scores on these scales should reveal their progress after defined amounts of time or at defined stages in treatment.

The technique used for assessing patients using the BAI

1. The patients should be assessed by the assessor on all items in the areas requested. Outside the requested areas, it would be useful if you would score as many other items as possible.
2. Your assessment must be made on the basis of the defined criteria for each item.
3. Assessment is by rating from 1 - 5 on the BAI, regarding each item, following the accompanying sheet.
4. Time needed for scoring should not be long, it should be quick - just your first reaction (having read the relevant criteria).
5. Judgement about different complaints made by the patient may be required before filling in the BAI eg a patient may lack insight in certain areas and deny a problem, but it in your clinical judgement it may be an area of difficulty.

NB In the BAI manual A refers to assessor and S refers to subjects

At this stage of developing the instrument, further professional contributions are needed. This will be done in particular by criticising the instrument (ie answering the questions raised).

As an assessor you are asked to comment about the following:

1. The importance of every item included, from the therapeutic point of view, regardless of your specialised interests.
2. The usefulness of the items included, ie some items could be important but not useful to include as no therapeutic intervention could be employed on them. Thus items of significance to the patient and to therapy should be emphasised.
3. The suitability of the assessment situation. Some items can be covered in an interview situation, while others cannot. In particular, I feel that it might be quite fair to judge some items that are not viable at interview, if the interviewer asks the patient about them (eg coping at home). I particularly want to have your judgement about such items.
4. The assessment criterion for each item. The raters should comment about the relevance, clarity and consistency of the criteria for each item. Suggestions for improving the criteria in more measurable terms are particularly required.

SECTION A: Communication and social skills

1. Displays appropriate facial expressions

Assessment situation: Interview

Criterion: S uses a variety of facial reactions consistent with the subjects discussed

Important	Useful	Criterion Relevant	Situation Assessment	Problems/suggestions
Y/N	Y/N	Y/N	Poss/imposs	

2. Makes/maintains eye contact for reasonable periods

Assessment situation: Interview

Criterion: S should be able to look directly at A as appropriate. Also it should not be prolonged eye contact that might cause embarrassment to A

Important	Useful	Criterion Relevant	Situation Assessment	Problems/suggestions
Y/N	Y/N	Y/N	Poss/imposs	

3. Is able to relax and adapt appropriate body posture

Assessment situation: Interview

Criterion: S maintains a comfortable body posture with no signs of tension, rigidity or irritability

Important	Useful	Criterion Relevant	Situation Assessment	Problems/suggestions
Y/N	Y/N	Y/N	Poss/imposs	

4. Uses appropriate body movements

Assessment situation: Interview

Criterion: S uses movements of head/hands/shoulders/trunk etc appropriately and spontaneously to assist his/her communication

Important	Useful	Criterion Relevant	Situation Assessment	Problems/suggestions
Y/N	Y/N	Y/N	Poss/imposs	

5. Maintains "comfortable" social distance

Assessment situation: Interview

Criterion: Shows no signs of tension or discomfort from socially acceptable distance, ie not so distant as to upset the communication process, or so close as to embarrass A. Cultural differences/sex differences etc should be considered

Important	Useful	Criterion Relevant	Situation Assessment	Problems/suggestions
Y/N	Y/N	Y/N	Poss/imposs	

6. Speaks fluently with varied/expressive tone of voice and appropriate speed

Assessment situation: Interview

Criterion: S is able to change tone of voice in response to his/her cognitive and emotional status in a coherent/relevant form

Important	Useful	Criterion Relevant	Situation Assessment	Problems/suggestions
Y/N	Y/N	Y/N	Poss/imposs	

7. Initiates conversation or actively participates when normally appropriate

Assessment situation: Interview

Criterion: S must respond to gaps in the conversation by initiating appropriate talk as occasion arises

Important	Useful	Criterion Relevant	Situation Assessment	Problems/suggestions
Y/N	Y/N	Y/N	Poss/imposs	

8. Keeps the conversation within socially correct trends

Assessment situation: Interview/other sources

Criterion: S should use socially acceptable language in accordance with his/her culture/social class and/or level of education

Important	Useful	Criterion Relevant	Situation Assessment	Problems/suggestions
Y/N	Y/N	Y/N	Poss/imposs	

9. Waits for his/her turn to speak

Assessment situation: Interview/other sources

Criterion: S should be able not to intrude in conversation while others are speaking. Also he/she should be able to make use of his/her turn to speak

Important	Useful	Criterion Relevant	Situation Assessment	Problems/suggestions
Y/N	Y/N	Y/N	Poss/imposs	

10. Talks about self as appropriate

Assessment situation: Interview/other sources

Criterion: S is able to conduct a substantial part of the conversation without unnecessary self-reference. Also should be able to talk about self when necessary

Important	Useful	Criterion Relevant	Situation Assessment	Problems/suggestions
Y/N	Y/N	Y/N	Poss/imposs	

11. Responds effectively to questions

Assessment situation: Interview

Criterion: S is able to answer questions directed to him/her in a coherent, relevant, rational and comprehensible form

Important	Useful	Criterion Relevant	Situation Assessment	Problems/suggestions
Y/N	Y/N	Y/N	Poss/imposs	

12. Listens attentively/actively to others during conversation

Assessment situation: Interview/other sources

Criterion: S clearly shows evidence of actively listening to others by using facial expressions or body movements

Important	Useful	Criterion Relevant	Situation Assessment	Problems/suggestions
Y/N	Y/N	Y/N	Poss/imposs	

13. Communicates spontaneously with others

Assessment situation: Interview/other sources

Criterion: S is able to communicate with A and/or other people not known to him/her in a relaxed, uninhibited, expressive manner

Important	Useful	Criterion Relevant	Situation Assessment	Problems/suggestions
Y/N	Y/N	Y/N	Poss/imposs	

14. Converses about a variety of subjects

Assessment situation: Interview/other sources

Criterion: S is able to converse about more than one subject spontaneously without being over-obsessed with one topic only

Important	Useful	Criterion Relevant	Situation Assessment	Problems/suggestions
Y/N	Y/N	Y/N	Poss/imposs	

15. Can live with others on peaceful terms

Assessment situation: Interview/other sources

Criterion: S can get on well with others, maintain a peaceful atmosphere with others when he/she is sharing their everyday life

Important	Useful	Criterion Relevant	Situation Assessment	Problems/suggestions
Y/N	Y/N	Y/N	Poss/imposs	

16. Express opinions in non-aggressive, socially acceptable manner

Assessment situation: Interview/other sources

Criterion: S discusses his/her different opinions without being hostile, agitated, angry or inhibited

Important	Useful	Criterion Relevant	Situation Assessment	Problems/suggestions
Y/N	Y/N	Y/N	Poss/imposs	

17. Is able to be assertive when necessary

Assessment situation: Interview/other sources

Criterion: S is able to defend himself/herself in any critical situation and would say 'No' when necessary

Important	Useful	Criterion Relevant	Situation Assessment	Problems/suggestions
Y/N	Y/N	Y/N	Poss/imposs	

18. Is able to accept success and failure in general and willingly admits to errors

Assessment situation: Interview/other sources

Criterion: S discusses mistakes rationally and accepts the possibility of having committed errors

Important	Useful	Criterion Relevant	Situation Assessment	Problems/suggestions
Y/N	Y/N	Y/N	Poss/imposs	

19. Is outgoing and supportive to others

Assessment situation: Self report/other sources

Criterion: S should be able to help, support, show interest in other people

Important	Useful	Criterion Relevant	Situation Assessment	Problems/suggestions
Y/N	Y/N	Y/N	Poss/imposs	

SECTION B: Insight

20. Discusses personal feelings honestly

Assessment situation: Interview

Criterion: S discusses personal feelings with A including sensitive/ embarrassing ones, without hiding, covering or falsifying them to gain attention or for manipulative purposes

Important	Useful	Criterion Relevant	Situation Assessment	Problems/suggestions
Y/N	Y/N	Y/N	Poss/imposs	

21. Expresses emotions with appropriate self control

Assessment situation: Interview

Criterion: S is able to express his/her emotions without undue nervousness, aggression, panic, excitement or perpetual crying; also without being indifferent, apathetic or rigidly restrained

Important	Useful	Criterion Relevant	Situation Assessment	Problems/suggestions
Y/N	Y/N	Y/N	Poss/imposs	

22. Is aware when experiencing any negative feelings (ie fear, anger, frustration, sadness, hate etc)

Assessment situation: Interview/other sources

Criterion: S is able to identify the nature of negative feelings and their intensity

Important	Useful	Criterion Relevant	Situation Assessment	Problems/suggestions
Y/N	Y/N	Y/N	Poss/imposs	

23. Can identify thoughts or events that arouse negative feelings

Assessment situation: Interview

Criterion: S is able to recognise the type of thoughts or events that provoke any of these negative feelings

Important	Useful	Criterion Relevant	Situation Assessment	Problems/suggestions
Y/N	Y/N	Y/N	Poss/imposs	

24. Can identify thoughts and events that are relaxing and pleasurable

Assessment situation: Interview

Criterion: S is able to describe the type of thoughts or events that are calming and bring a sense of pleasure to him/her

Important	Useful	Criterion Relevant	Situation Assessment	Problems/suggestions
Y/N	Y/N	Y/N	Poss/imposs	

25. Uses appropriate coping strategies when distressed -

Assessment situation: Interview/other sources

Criterion: S is able to describe a personal, constructive method for attempting to reduce distressful feelings

Important	Useful	Criterion Relevant	Situation Assessment	Problems/suggestions
Y/N	Y/N	Y/N	Poss/imposs	

26. Can describe/identify the person(s) whom he/she trusts/distrusts

Assessment situation: Interview

Criterion: S is able to name the person(s) who gained his/her trust/distrust, and will be able to say why, with supporting detail/evidence

Important	Useful	Criterion Relevant	Situation Assessment	Problems/suggestions
Y/N	Y/N	Y/N	Poss/imposs	

27. Can identify incidents that make him/her secure or insecure

Assessment situation: Interview

Criterion: S is able to describe real incidents that produce insecure feelings, or could produce reassurance and security

Important	Useful	Criterion Relevant	Situation Assessment	Problems/suggestions
Y/N	Y/N	Y/N	Poss/imposs	

28. Can describe the actual events that led to his/her present course of treatment

Assessment situation: Interview

Criterion: S is able to identify the real links in the chain of antecedent events leading to his/her current need for treatment

Important	Useful	Criterion Relevant	Situation Assessment	Problems/suggestions
Y/N	Y/N	Y/N	Poss/imposs	

29. Can recognise rationally whether his/her actions were responsible for these problems

Assessment situation: Interview

Criterion: S is able to link sensibly his/her action to the resulting problematic situations, without either excessive self-blame or complete denial of responsibility

Important	Useful	Criterion Relevant	Situation Assessment	Problems/suggestions
Y/N	Y/N	Y/N	Poss/imposs	

30. Makes a realistic appraisal of his/her current problems

Assessment situation: Interview

Criterion: S is able to show realistic understanding of the nature of his/her problems and the first priority areas to be dealt with from the therapeutic point of view

Important	Useful	Criterion Relevant	Situation Assessment	Problems/suggestions
Y/N	Y/N	Y/N	Poss/imposs	

31. Shows appropriate confidence in self, physically, intellectually, emotionally

Assessment situation: Interview

Criterion: S expresses honestly a self view of acceptance of his/her physical, intellectual and emotional shape

Important	Useful	Criterion Relevant	Situation Assessment	Problems/suggestions
Y/N	Y/N	Y/N	Poss/imposs	

32. Has appropriate expectations regarding short and long term achievements

Assessment situation: Interview

Criterion: S is able to demonstrate realistic expectations regarding the outcomes of his/her treatment and potential personal capacities/limitations

Important	Useful	Criterion Relevant	Situation Assessment	Problems/suggestions
Y/N	Y/N	Y/N	Poss/imposs	

33. Can decide upon sensible/appropriate/workable course of action in dealing with his/her problems

Assessment situation: Interview

Criterion: S can recognise the logic of possible treatment that is most helpful to deal with these problems

Important	Useful	Criterion Relevant	Situation Assessment	Problems/suggestions
Y/N	Y/N	Y/N	Poss/imposs	

34. Demonstrates realistic awareness of his/her own strengths/limitations in selecting appropriate activities

Assessment situation: Interview/other sources

Criterion: S is able to describe a range of activities that he/she can pursue successfully with consideration of other feelings such as age, sex and culture

Important	Useful	Criterion Relevant	Situation Assessment	Problems/suggestions
Y/N	Y/N	Y/N	Poss/imposs	

35. Displays natural interest in potential sexual partners

Assessment situation: Self report/other sources

Criterion: S expresses positive attitude towards having a sexual partner.
Cultural and religious factors should be taken into account

Important	Useful	Criterion Relevant	Situation Assessment	Problems/suggestions
Y/N	Y/N	Y/N	Poss/imposs	

36. Demonstrates a realistic awareness of his/her sexual needs

Assessment situation: Interview

Criterion: S is able to identify his/her sexual needs and is able to discuss realistically the different dimensions of his/her needs
(eg heterosexual/homosexual)

Important	Useful	Criterion Relevant	Situation Assessment	Problems/suggestions
Y/N	Y/N	Y/N	Poss/imposs	

37. Behaves in a relaxed and friendly way towards both sexes during social activities

Assessment situation: Self report/other sources

Criterion: S reports his/her ability to relax and unwind in the presence of the other sex (cultural factors). He/she will not be indifferent or excessively interested

Important	Useful	Criterion Relevant	Situation Assessment	Problems/suggestions
Y/N	Y/N	Y/N	Poss/imposs	

38. is able to develop and maintain an appropriate sexual relationship

Assessment situation: Self report/other sources

Criterion: S is able to prove that he/she is able to start an appropriate sexual relationship and keep up with its demands

Important	Useful	Criterion Relevant	Situation Assessment	Problems/suggestions
Y/N	Y/N	Y/N	Poss/imposs	

39. Collaborates with others in this type of problem discussion and problem-solving

Assessment situation: Interview/other sources

Criterion: S is able to discuss his/her potential therapy positively and co-operate with A to identify the solution for his/her problems

Important	Useful	Criterion Relevant	Situation Assessment	Problems/suggestions
Y/N	Y/N	Y/N	Poss/imposs	

SECTION C: Self and family care

40. Attends to details of cleanliness, tidiness and grooming

Assessment situation: Interview

Criterion: S appears clean/tidy according to reasonable standards in the interview context

Important	Useful	Criterion Relevant	Situation Assessment	Problems/suggestions
Y/N	Y/N	Y/N	Poss/imposs	

41. Pursues self-care and personal hygiene

Assessment situation: Self report/other sources

Criterion: S is able to look after his/her personal cleanliness and self care appropriately and regularly, with no complaints of over- or under-doing this

Important	Useful	Criterion Relevant	Situation Assessment	Problems/suggestions
Y/N	Y/N	Y/N	Poss/imposs	

42. Dress appropriately according to weather and occasion

Assessment situation: Interview

Criterion: A observes that S wears suitable clothes: warm enough, well-fitting and not over-fancy

Important	Useful	Criterion Relevant	Situation Assessment	Problems/suggestions
Y/N	Y/N	Y/N	Poss/imposs	

43. Maintains clothes in good condition

Assessment situation: Self report/other sources

Criterion: S is able to keep his/her clothes clean and well-maintained without being obsessed with this

Important	Useful	Criterion Relevant	Situation Assessment	Problems/suggestions
Y/N	Y/N	Y/N	Poss/imposs	

44. Appears well-nourished with normal weight for height and build, ie not under or over weight

Assessment situation: Interview

Criterion: S's weight should be within normal limits, in relation to height, build, sex, age and cultural norms

Important	Useful	Criterion Relevant	Situation Assessment	Problems/suggestions
Y/N	Y/N	Y/N	Poss/imposs	

45. Has appropriate eating habits

Criterion: S is able to keep regular meal times and eats appropriate amounts of a well-balanced diet. Also any symptoms of compulsive eating/bingeing or vomiting should be absent

Important	Useful	Criterion Relevant	Situation Assessment	Problems/suggestions
Y/N	Y/N	Y/N	Poss/imposs	

46. Is able to eat out if the need arises

Assessment situation: Self report/other sources

Criterion: S displays no difficulty in finding a cafe/restaurant to eat in, if needed; ordering and paying and not complaining about being threatened at having other people see him/her eating

Important	Useful	Criterion Relevant	Situation Assessment	Problems/suggestions
Y/N	Y/N	Y/N	Poss/imposs	

47. Displays acceptable table manners

Assessment situation: Self report/other sources

Criterion: S's table manners are consistent with his/her socio-cultural/ethnic background and he/she does not upset other people sharing a meal with them

Important	Useful	Criterion Relevant	Situation Assessment	Problems/suggestions
Y/N	Y/N	Y/N	Poss/imposs	

48. Is able to prepare suitable and adequate meals for himself/herself and/or family/others

Assessment situation: Self report/other sources

Criterion: S can discuss the steps in preparing a meal, and displays awareness of the components of a balanced diet

Important	Useful	Criterion Relevant	Situation Assessment	Problems/suggestions
Y/N	Y/N	Y/N	Poss/imposs	

49. Keeps an adequate stock of essential food stuff in a hygienic way

Assessment situation: Self report/other sources

Criterion: S demonstrates evidence of keeping essential food items in appropriate conditions

Important	Useful	Criterion Relevant	Situation Assessment	Problems/suggestions
Y/N	Y/N	Y/N	Poss/imposs	

50. Is able to shop for his/her own household necessities

Assessment situation: Self report

Criterion: S is able, without difficulty, to decide upon the required items and money needed

Important	Useful	Criterion Relevant	Situation Assessment	Problems/suggestions
Y/N	Y/N	Y/N	Poss/imposs	

51. Washes up and cleans up systematically

Assessment situation: Self report/other sources

Criterion: S displays evidence of appropriate domestic skills relevant to socio-cultural/ethnic expectations.

Important	Useful	Criterion Relevant	Situation Assessment	Problems/suggestions
Y/N	Y/N	Y/N	Poss/imposs	

52. Guards against common household dangers

Assessment situation: Self report/other sources

Criterion: S is safety conscious and is able to avoid common household dangers

Important	Useful	Criterion Relevant	Situation Assessment	Problems/suggestions
Y/N	Y/N	Y/N	Poss/imposs	

53. Undertakes general household chores effectively

Assessment situation: Self report/other sources

Criterion: S is able to demonstrate the ability to perform general household tasks as required, without over doing them or completely neglecting them

Important	Useful	Criterion Relevant	Situation Assessment	Problems/suggestions
Y/N	Y/N	Y/N	Poss/imposs	

54. Manages personal/family finances adequately

Assessment situation: Self report/other sources

Criterion: S is able to discuss or displays insight and logic about spending their income on different household resources (eg coal, electricity etc) or other everyday life needs

Important	Useful	Criterion Relevant	Situation Assessment	Problems/suggestions
Y/N	Y/N	Y/N	Poss/imposs	

55. Takes responsibility for everyday personal and family needs

Assessment situation: Self report/other sources

Criterion: S is able to provide evidence of effectively carrying out different necessary everyday life duties (eg looking after children or conserve household resources)

Important	Useful	Criterion Relevant	Situation Assessment	Problems/suggestions
Y/N	Y/N	Y/N	Poss/imposs	

56. Has friendly, warm mutual relationships with his/her family members

Assessment situation: Probing interview

Criterion: S is able to describe the nature of relationships between him/her and the family members and to demonstrate evidence of mutual acceptance, love, affection, sympathy and support

Important	Useful	Criterion Relevant	Situation Assessment	Problems/suggestions
Y/N	Y/N	Y/N	Poss/imposs	

57. Deals effectively/objectively with different family problems

Assessment situation: Probing interview

Criterion: S is able to discuss and undertake active, constructive intervention to deal with family problems

Important	Useful	Criterion Relevant	Situation Assessment	Problems/suggestions
Y/N	Y/N	Y/N	Poss/imposs	

58. Seeks medical help for self and family when required

Assessment situation: Self report/other sources

Criterion: S is able to identify the need for medical help; when/how to obtain it with no hesitation/being over-demanding or manipulative

Important	Useful	Criterion Relevant	Situation Assessment	Problems/suggestions
Y/N	Y/N	Y/N	Poss/imposs	

59. Is able to go about own neighbourhood

Assessment situation: Self report/other sources

Criterion: S displays interest in going about neighbourhood, for social visits or help and support, in a competent and independent way

Important	Useful	Criterion Relevant	Situation Assessment	Problems/suggestions
Y/N	Y/N	Y/N	Poss/imposs	

SECTION D: -Work and recreation

60. Carries out work duties with a sense of responsibility

Assessment situation: Self report/other sources

Criterion: S is able to display a tendency for regular, systematic performance of his/her duties without delay or unconvincing excuses

Important	Useful	Criterion Relevant	Situation Assessment	Problems/suggestions
Y/N	Y/N	Y/N	Poss/imposs	

61. Quality of work meets with the desired standards

Assessment situation: Self report/other sources

Criterion: S shows that his/her work quality is acceptable to others and that it adds to his/her personal success/sense of achievement

Important	Useful	Criterion Relevant	Situation Assessment	Problems/suggestions
Y/N	Y/N	Y/N	Poss/imposs	

62. Shows concentration/interest to carry out instructions without difficulty

Assessment situation: Self report/other sources

Criterion: S shows that his/her work quality is acceptable to others and that it adds to his/her personal success/sense of achievement

Important	Useful	Criterion Relevant	Situation Assessment	Problems/suggestions
Y/N	Y/N	Y/N	Poss/imposs	

63. Adapts appropriately to the working environment and team situation

Assessment situation: Probing interview

Criterion: S is able to carry out satisfactorily most of the required tasks within the working situation including coping with the different conflicts and challenges at work and with other team members

Important	Useful	Criterion Relevant	Situation Assessment	Problems/suggestions
Y/N	Y/N	Y/N	Poss/imposs	

64. Has few and unavoidable absences

Assessment situation: Self report/other sources

Criterion: S attends work regularly and follows the work regime. S must be able to accept having holidays or casual absences if the need arises. (Work in that sense means job, housewife duties, school or any educational institution, day hospital, day centres etc)

Important	Useful	Criterion Relevant	Situation Assessment	Problems/suggestions
Y/N	Y/N	Y/N	Poss/imposs	

65. Uses private and public transport

Assessment situation: Self report/other sources

Criterion: S displays no tension or difficulty in using own private or public transport

Important	Useful	Criterion Relevant	Situation Assessment	Problems/suggestions
Y/N	Y/N	Y/N	Poss/imposs	

66. Can identify, pursue and enjoy a varied selection of hobbies and activities

Assessment situation: Interview

Criterion: S is able to identify a number of varied leisure activities in which he/she takes part on a fairly regular basis

Important	Useful	Criterion Relevant	Situation Assessment	Problems/suggestions
Y/N	Y/N	Y/N	Poss/imposs	

67. Can programme his/her individual and group activities

Assessment situation: Probing interview

Criterion: S is able to cite examples of some of the activities he/she programmed, either to oneself or to a group of people (colleagues/friends, family etc)

Important	Useful	Criterion Relevant	Situation Assessment	Problems/suggestions
Y/N	Y/N	Y/N	Poss/imposs	

APPENDIX 11

SHEFFIELD CITY POLYTECHNIC
DEPARTMENT OF HEALTH STUDIES
FACULTY OF EDUCATION, HEALTH AND WELFARE

THE BEHAVIOURAL ADJUSTMENT INVENTORY (BAI)

A Draft Manual (Modified Version II)

Details

Name.....

Occupation.....

SECTION A: Communication and social skills

The assessment situation used for all the items in this section is by interview or conversation

1. Shows appropriate non-verbal communication behaviour during conversation

Criterion: S uses a variety of facial reactions, comfortable body posture and appropriate eye contact and gestures

Important	Useful	Criterion Relevant	Situation Assessment	Problems/suggestions
Y/N	Y/N	Y/N	Poss/imposs	

2. Initiates conversation or actively participates when normally appropriate

Criterion: S must respond to gaps in the conversation by initiating appropriate talk as occasion arises

Important	Useful	Criterion Relevant	Situation Assessment	Problems/suggestions
Y/N	Y/N	Y/N	Poss/imposs	

3. Waits for his/her turn to speak

Criterion: S should be able not to intrude in conversation while others are speaking. Also he/she should be able to make use of his/her turn to speak

Important	Useful	Criterion Relevant	Situation Assessment	Problems/suggestions
Y/N	Y/N	Y/N	Poss/imposs	

4. Talks about self as appropriate

Criterion: S is able to conduct a substantial part of the conversation without unnecessary self-reference. Also should be able to talk about self when necessary

Important	Useful	Criterion Relevant	Situation Assessment	Problems/suggestions
Y/N	Y/N	Y/N	Poss/imposs	

5. Responds appropriately to questions

Criterion: S is able to answer questions directed to him/her in a coherent, relevant, rational and comprehensible form

Important	Useful	Criterion Relevant	Situation Assessment	Problems/suggestions
Y/N	Y/N	Y/N	Poss/imposs	

6. Listens attentively/actively to others during conversation

Criterion: S clearly shows evidence of actively listening to others by using facial expressions or body movements

Important	Useful	Criterion Relevant	Situation Assessment	Problems/suggestions
Y/N	Y/N	Y/N	Poss/imposs	

7. Can live with others on peaceful terms

Criterion: S can get on well with others, maintain a peaceful atmosphere with others when he/she is sharing their everyday life

Important	Useful	Criterion Relevant	Situation Assessment	Problems/suggestions
Y/N	Y/N	Y/N	Poss/imposs	

8. Is able to be assertive when necessary

Criterion: S is able to defend himself/herself in any critical situation and would say 'No' when necessary

Important	Useful	Criterion Relevant	Situation Assessment	Problems/suggestions
Y/N	Y/N	Y/N	Poss/imposs	

9. Is able to accept success and failure in general and willingly admits to errors

Criterion: S discusses mistakes rationally and accepts the possibility of having committed errors

Important	Useful	Criterion Relevant	Situation Assessment	Problems/suggestions
Y/N	Y/N	Y/N	Poss/imposs	

SECTION B: Insight

The assessment situation used for all the items in this section is by interview or provoked conversation

10. Discusses personal feelings honestly

Criterion: S discusses personal feelings with A including sensitive/ embarrassing ones, without hiding, covering or falsifying them to gain attention or for manipulative purposes

Important	Useful	Criterion Relevant	Situation Assessment	Problems/suggestions
Y/N	Y/N	Y/N	Poss/imposs	

11. Is aware when experiencing any negative feelings (ie fear, anger, frustration, sadness, hate etc)

Criterion: S is able to identify the nature of negative feelings and their intensity

Important	Useful	Criterion Relevant	Situation Assessment	Problems/suggestions
Y/N	Y/N	Y/N	Poss/imposs	

12. Can identify thoughts or events that arouse negative feelings

Criterion: S is able to recognise the type of thoughts or events that provoke any of these negative feelings

Important	Useful	Criterion Relevant	Situation Assessment	Problems/suggestions
Y/N	Y/N	Y/N	Poss/imposs	

13. Can identify/describe real incidents that make him/her feel secure or insecure

Criterion: S is able to describe real incidents that produce insecure feelings, or could produce reassurance and security

Important	Useful	Criterion Relevant	Situation Assessment	Problems/suggestions
Y/N	Y/N	Y/N	Poss/imposs	

14. Makes a realistic appraisal of his/her current problems

Criterion: S is able to show realistic understanding of the nature of his/her problems and the first priority areas to be dealt with from the therapeutic point of view

Important	Useful	Criterion Relevant	Situation Assessment	Problems/suggestions
Y/N	Y/N	Y/N	Poss/imposs	

15. Shows appropriate confidence in own worth

Criterion: S can take an honest and accepting view of his/her worthiness and capabilities

Important	Useful	Criterion Relevant	Situation Assessment	Problems/suggestions
Y/N	Y/N	Y/N	Poss/imposs	

16. Has appropriate expectations regarding short and long term achievements

Criterion: S is able to demonstrate realistic expectations regarding the outcomes of his/her treatment and potential personal capacities/limitations

Important	Useful	Criterion Relevant	Situation Assessment	Problems/suggestions
Y/N	Y/N	Y/N	Poss/imposs	

17. Can decide upon sensible/appropriate/workable course of action in dealing with his/her problems

Criterion: S can recognise the logic of possible treatment plans that are helpful to deal with his/her problems

Important	Useful	Criterion Relevant	Situation Assessment	Problems/suggestions
Y/N	Y/N	Y/N	Poss/imposs	

18. Behaves in an appropriate way towards both sexes

Criterion: S reports his/her ability to relax and unwind in the presence of the other sex (cultural factors). He/she will not be indifferent or excessively interested

Important	Useful	Criterion Relevant	Situation Assessment	Problems/suggestions
Y/N	Y/N	Y/N	Poss/imposs	

SECTION C: Self and family care

Assessment situations used for the items in this section are varied: interview, family, patient records, home visits etc

19. Pursue self-care and personal hygiene

Criterion: S is able to look after his/her personal cleanliness and self care appropriately and regularly, with no complaints of over- or under-doing this

Important	Useful	Criterion Relevant	Situation Assessment	Problems/suggestions
Y/N	Y/N	Y/N	Poss/imposs	

20. Appears well-nourished with normal weight for height and build, ie not under or over weight

Criterion: S's weight should be within normal limits, in relation to height, build, sex, age and cultural norms

Important	Useful	Criterion Relevant	Situation Assessment	Problems/suggestions
Y/N	Y/N	Y/N	Poss/imposs	

21. Has appropriate eating habits

Criterion: S is able to keep regular meal times and eats appropriate amounts of a well-balanced diet. Also any symptoms of compulsive eating/bingeing or vomiting should be absent

Important	Useful	Criterion Relevant	Situation Assessment	Problems/suggestions
Y/N	Y/N	Y/N	Poss/imposs	

22. Is able to prepare suitable and adequate meals for himself/herself and/or family/others

Criterion: S can discuss the steps in preparing a meal, and displays awareness of the components of a balanced diet

Important	Useful	Criterion Relevant	Situation Assessment	Problems/suggestions
Y/N	Y/N	Y/N	Poss/imposs	

23. Is able to manage shopping trips successfully including appropriate purchasing and payment

Criterion: S is able, without difficulty, to decide upon the required items and money needed and can get the job done

Important	Useful	Criterion Relevant	Situation Assessment	Problems/suggestions
Y/N	Y/N	Y/N	Poss/imposs	

24. Guards against common household dangers

Criterion: S is safety conscious and is able to avoid common household dangers

Important	Useful	Criterion Relevant	Situation Assessment	Problems/suggestions
Y/N	Y/N	Y/N	Poss/imposs	

25. Manages personal/family finances adequately

Criterion: S is able to discuss or displays insight and logic about spending their income on different household resources (eg coal, electricity etc) or other everyday life needs

Important	Useful	Criterion Relevant	Situation Assessment	Problems/suggestions
Y/N	Y/N	Y/N	Poss/imposs	

26. Takes responsibility for everyday personal and family needs

Criterion: S is able to provide evidence of effectively carrying out different necessary everyday life duties (eg looking after children or conserve household resources)

Important	Useful	Criterion Relevant	Situation Assessment	Problems/suggestions
Y/N	Y/N	Y/N	Poss/imposs	

27. Deals effectively/objectively with different family problems

Criterion: S is able to discuss and undertake active, constructive intervention to deal with family problems

Important	Useful	Criterion Relevant	Situation Assessment	Problems/suggestions
Y/N	Y/N	Y/N	Poss/imposs	

28. Seeks medical help for self and family when required

Criterion: S is able to identify the need for medical help; when/how to obtain it with no hesitation/being over-demanding or manipulative

Important	Useful	Criterion Relevant	Situation Assessment	Problems/suggestions
Y/N	Y/N	Y/N	Poss/imposs	

29. Carries out work duties with a sense of responsibility

Criterion: S is able to display a tendency for regular, systematic performance of his/her duties without delay or unconvincing excuses

Important	Useful	Criterion Relevant	Situation Assessment	Problems/suggestions
Y/N	Y/N	Y/N	Poss/imposs	

30. Can identify, pursue and enjoy a varied selection of hobbies and activities

Criterion: S is able to identify a number of varied leisure activities in which he/she takes part on a fairly regular basis

Important	Useful	Criterion Relevant	Situation Assessment	Problems/suggestions
Y/N	Y/N	Y/N	Poss/imposs	

BEHAVIOURAL ADJUSTMENT INVENTORY (BAI)

(ASSESSMENT FORM)

PATIENT'S NAME :

ADDRESS :

AGE :

SEX :

MARITAL STATUS :

OCCUPATION :

DATE OF ADMISSION:

DATE OF DISCHARGE:

REASON FOR ADMISSION:

Please place a ✓ in the appropriate column

SECTION A: COMMUNICATION AND SOCIAL SKILLS

Item and Criterion	Worst possible situation	1	2	3	4	5	Best possible situation
1. Shows appropriate non-verbal communication behaviour during conversation. (Criterion: S uses a variety of facial reactions, comfortable body posture and appropriate eye contact and gestures)	Completely absent						Wholly appropriate
2. Initiates conversation or actively participates when normally appropriate. (Criterion: S must respond to gaps in the conversation by initiating appropriate talk as occasion arises)	Worst possible situation						Best possible situation
3. Waits for his/her turn to speak. (Criterion: S should be able not to intrude in conversation while others are speaking)	Worst possible situation						Best possible situation
4. Talks about self as appropriate. (Criterion: S is able to conduct a substantial part of the conversation without unnecessary self-reference. Also should be able to talk about self when necessary)	Worst possible situation						Best possible situation
5. Responds appropriately to questions. (Criterion: S is able to answer questions directed to him/her in a coherent, relevant, rational and comprehensible form)	Worst possible situation						Best possible situation

Item and Criterion	Worst possible situation	1	2	3	4	5	Best possible situation
6. Listens attentively/actively to others during conversation (Criterion: S clearly shows evidence of actively listening to others by using facial expressions or body movements)	Completely absent						Wholly appropriate
7. Can live with others on peaceful terms. (Criterion: S perceives himself/herself as getting on well with others is maintaining a peaceful atmosphere with others when he/she is sharing their everyday life)	Worst possible situation						Best possible situation
8. Is able to be assertive when necessary. (Criterion: S is able to defend himself/herself in any critical situation and would say 'No' when necessary)	Worst possible situation						Best possible situation
9. Is able to accept success and failure in general and willingly admits to errors. (Criterion: S discusses mistakes rationally and accepts the possibility of having committed errors without undue feelings of guilt and is able to consider the possibility of repeating mistakes)	Worst possible situation						Best possible situation

SECTION B: INSIGHT

Item and Criterion	Worst possible situation	1	2	3	4	5	Best possible situation
10. Discuss personal feelings. (Criterion: S discusses personal feelings with A including sensitive/embarrassing ones, without hiding, covering or falsifying them to gain attention or for manipulative purposes)	Completely absent						Wholly appropriate
11. Is aware when experiencing any negative feelings (ie fear, anger, frustration, sadness, hate etc). (Criterion: S is able to identify the nature of negative feelings and their intensity and accepts their presence)	Worst possible situation						Best possible situation
12. Can identify thoughts or events that arouse negative feelings. (Criterion: S is able to recognise the type of thoughts or events that provoke any of these negative feelings)	Worst possible situation						Best possible situation
13. Can identify/describe real incidents that make him/her feel secure or insecure. (Criterion: S is able to describe real incidents that produce insecure feelings, or could produce reassurance and security)	Worst possible situation						Best possible situation

Item and Criterion	Worst possible situation	1	2	3	4	5	Best possible situation
14. Makes a realistic appraisal of his/her current problems. (Criterion: S is able to show realistic understanding of the nature of his/her problems and the first priority areas to be dealt with from the therapeutic point of view)	Completely absent						Wholly appropriate
15. Shows appropriate confidence in own worth. (Criterion: S can take an honest and accepting view of his/her worthiness and capabilities)	Worst possible situation						Best possible situation
16. Has appropriate expectations regarding short and long term achievements. (Criterion: S is able to demonstrate realistic expectations regarding the outcomes of his/her treatment and potential personal capacities/limitations)	Worst possible situation						Best possible situation
17. Can decide upon sensible/appropriate/workable course of action in dealing with his/her problems. (Criterion: S can recognise the logic of possible treatment plans that are helpful to deal with his/her problems)	Worst possible situation						Best possible situation
18. Has conventional interests in both sexes. (Criterion: S reports/displays appropriate sexual interest and behaviour, not anxious/indifferent or excessively interested in the presence of potential partners)	Worst possible situation						Best possible situation

SECTION C: SELF AND FAMILY CARE

Item and Criterion	Worst possible situation	1	2	3	4	5	Best possible situation
19. Pursue self-care and personal hygiene. (Criterion: S is able to look after his/her personal cleanliness and self care appropriately and regularly with no complaints of over- or under-doing this)	Completely absent						Wholly appropriate
20. Appears well-nourished with normal weight for height and build, is not under or over weight. (Criterion: S's weight should be within normal limits, in relation to height build, sex, age and cultural norms)	Worst possible situation						Best possible situation
21. Has appropriate eating habits (Criterion: S is able to keep regular meal times and eats appropriate amounts of a well-balanced diet. Also any symptoms of compulsive eating/ bingeing or vomiting should be absent)	Worst possible situation						Best possible situation
22. Is able to prepare suitable and adequate meals for himself/herself and or family/ others if the need exists. (Criterion: S reports about his/her ability to do so and other sources of evidence)	Worst possible situation						Best possible situation

Item and Criterion	possible situation	1	2	3	4	5	possible situation
23. Is able to manage shopping trips successfully including appropriate purchasing and payment if the need exists. (Criterion: S is able, without difficulty, to decide upon the required items and money needed and can get the job done)	Completely absent						Wholly appropriate
24. Guards against common household dangers. (Criterion: S is safety conscious and is able to avoid common household dangers)	Worst possible situation						Best possible situation
25. Manages personal/family finances adequately. (Criterion: S is able to discuss or displays insight and logic about spending their income on different household resources (eg coal, electricity etc) or other everyday life needs)	Worst possible situation						Best possible situation
26. Takes responsibility for everyday personal and family needs. (Criterion: S is able to provide evidence of effectively carrying out different necessary everyday life duties (eg looking after children or conserve household resources)	Worst possible situation						Best possible situation

Item and Criterion	Worst possible situation	1	2	3	4	5	Best possible situation
27. Deals effectively/objectively with different family problems. (Criterion: S is able to discuss and undertake active, constructive intervention to deal with family problems)	Completely absent						Wholly appropriate
28. Seeks medical help for self and family when required. (Criterion: S is able to identify when/how to obtain medical help without hesitation or manipulation)	Worst possible situation						Best possible situation
29. Carries out work duties with a sense of responsibility. (Criterion: S is able to display a tendency for regular, systematic performance of his/her duties without delay or unconvincing excuses)	Worst possible situation						Best possible situation
30. Can identify, pursue and enjoy a varied selection of hobbies and activities. (Criterion: S is able to identify a number of varied leisure activities in which he/she takes part on a fairly regular basis)	Worst possible situation						Best possible situation

أرجو قراءة ما يلي باهتمام :

نرغب بالمعرفة ان كنت تشكو من أى شكوى أو علة أو الام ناتجة من خلل فى صحتك وكيف حال صحتك خلال الاسابيع القليلة الماضية أرجو منك الاجابة على هذه الاسئلة ووضع خط تحت الاجابة التى تطابق حالتك • نذكرك باننا نرغب بمعرفة حالتك المحية فى الالونة الاخيرة وليس فى السابق •

نرجو المعرفة باننا من المهم جدا أن تجيب على جميع هذه الاسئلة

ونشكرك جدا على تعاونك معنا •

أقل كثيرا جدا من المادى	أقل من المادى	كالمادة	احسن من المادة	١ - هل تستطيع التركيز على أى عمل تقوم به •
أكثر بكثير من المادى	أكثر من المادة	ليس أكثر من المادة	كلا أبدا	٢ - هل التفتت الكثير من ساعات نومك نتيجة لاحاساك بالقلق •
أقل كثيرا جدا من المادى	أقل من المادى	كالمادة	أكثر من المادة	٣ - هل تشعر بانك تقوم بدور هام فى الامور التى حولك •
أقل كثيرا جدا من المادى	أقل من المادى	كالمادة	أكثر من المادة	٤ - هل شعرت بانك تستطيع اتخاذ القرارات الهامة فى الامور •
أكثر بكثير من المادى	أكثر من المادى	ليس أكثر من المادة	كلا أبدا	٥ - هل تشعر دائما بانك تحت ضغط •
أكثر بكثير من المادى	أكثر من المادى	ليس أكثر من المادة	كلا أبدا	٦ - هل شعرت بانك لا تستطيع التغلب على مصاعبك •
أقل كثيرا جدا من المادى	أقل من المادى	كالمادة	أكثر من المادى	٧ - هل شعرت بقدرتك على التمتع فى نشاطاتك اليومية •
أقل كثيرا جدا من المادى	أقل من المادى	كالمادة	أكثر من المادى	٨ - هل شعرت بقدرتك على مواجهة المشاكل •
أكثر بكثير من المادى	أكثر من المادى	ليس أكثر من المادة	كلا أبدا	٩ - هل شعرت بانك غير سعيد ومكتئب •
أكثر بكثير من المادى	أكثر من المادى	ليس أكثر من المادة	كلا أبدا	١٠ - هل شعرت بفقدان ثقتك بنفسك فى الالونة الاخيرة •
أكثر بكثير من المادى	أكثر من المادى	ليس أكثر من المادة	كلا أبدا	١١ - هل فكرت بانك شخص مدمر القيمة أو لا قيمة له •
أقل كثيرا جدا من المادى	أقل من المادى	كالمادة	أكثر من المادى	١٢ - هل شعرت بسعادة مقبولة وأن الامور على ما يرام •
أقل كثيرا جدا من المادى	أقل من المادى	كالمادة	أكثر من المادى	١٣ - هل تستطيع أن تجعل نفسك مشغولا باستمرار •
أقل كثيرا جدا من المادى	أقل من المادى	كالمادة	أكثر من المادى	١٤ - هل تخرج من المنزل كما تعودت من قبل •

١٥ - هل تشعر بأنك عموماً تقوم بتدبير الأمور تدبيراً حسناً .	أحسن من المادة	كالمادة	أقل من المادة	أقل كثيراً جداً من المادة
١٦ - هل شعرت بالرغبة من طريقة قيامك بمسلك .	أحسن من المادة	كالمادة	أقل من المادة	أقل كثيراً جداً من المادة
١٧ - هل تأخذ الأمور بمصوبة .	كلا أبداً	ليس أكثر من المادة	أكثر من المادة	أكثر بكثير من المادة
١٨ - هل وجدت بأن الأمور والظروف تنقلب وتتراكم عليك .	كلا أبداً	ليس أكثر من المادة	أكثر من المادة	أكثر بكثير من المادة
١٩ - هل شعرت بأنك مضى ومتوتر طوال الوقت .	كلا أبداً	ليس أكثر من المادة	أكثر من المادة	أكثر بكثير من المادة
٢٠ - هل وجدت أنك في بعض الآوقات لم تستطع القيام بمسل أي شيء لأن أمساكك في حالة سيئة .	كلا أبداً	ليس أكثر من المادة	أكثر من المادة	أكثر بكثير من المادة
٢١ - هل عانيت من ليال قلقة ومضطربة .	كلا أبداً	ليس أكثر من المادة	أكثر من المادة	أكثر بكثير من المادة
٢٢ - هل تقوم بتدبير الأمور كما يتدبرها معظم الناس إذا كانوا في محلك .	أكثر من المادة	كالمادة	أقل من المادة	أقل بكثير من المادة
٢٣ - هل لك القدرة على الاحساس بالدفء والحنان والمطافة من حولك .	أحسن من المادة	كالمادة	أقل من المادة	أقل كثيراً جداً من المادة
٢٤ - هل وجدت من السهل عليك التعامل والاختلاط بالآخرين .	أحسن من المادة	كالمادة	أقل من المادة	أقل كثيراً جداً من المادة
٢٥ - هل قضيت أوقات كثيرة في التحدث مع الناس .	كلا أبداً	ليس أكثر من المادة	أكثر من المادة	أكثر بكثير من المادة
٢٦ - هل وجدت أن الحياة صراع دائم .	كلا أبداً	ليس أكثر من المادة	أكثر من المادة	أكثر بكثير من المادة
٢٧ - هل شعرت بالخوف والهلع بدون سبب معقول .	كلا أبداً	ليس أكثر من المادة	أكثر من المادة	أكثر بكثير من المادة
٢٨ - هل شعرت بأن الحياة عديمة الامل تماماً .	كلا أبداً	ليس أكثر من المادة	أكثر من المادة	أكثر بكثير من المادة
٢٩ - هل شعرت بالامس في مستقبلك .	أكثر من المادة	كالمادة	أقل من المادة	أقل كثيراً جداً من المادة
٣٠ - هل شعرت بأن الحياة لا تستحق العيش .	كلا أبداً	ليس أكثر من المادة	أكثر من المادة	أكثر بكثير من المادة

العمر : الجنس (ذكر / أنثى) :

تعليمات :

نرجو أن تجيب عن كل سؤال من الأسئلة التالية بوضع دائرة حول كلمة "نعم" أو كلمة "لا" التي تسبق السؤال . ليست هناك لمجابات صحيحة وأخرى خاطئة ، وليست هناك أسئلة خادعة ، أجب بسرعة ولا تفكر كثيرا حول المعنى الدقيق للسؤال .
نرجو أن تتذكر أن تجيب عن كل سؤال .

- | | | |
|---|----|-----|
| ١ - هل لك هوايات كثيرة متنوعة ؟ | لا | نعم |
| ٢ - هل تتوقف لكي تفكر في الأمور قبل أن تقدم على عمل أى شيء ؟ | لا | نعم |
| ٣ - هل يتقلب مزاجك في أغلب الأحيان ؟ | لا | نعم |
| ٤ - هل حدث مرة أن قبلت المديح والثناء على شيء كنت تعرف أن شخصا آخر قام به ؟ | لا | نعم |
| ٥ - هل أنت كثير الكلام ؟ | لا | نعم |
| ٦ - هل يقلقك أن تكون عليك ديون ؟ | لا | نعم |
| ٧ - هل يحدث أحيانا أن تشعر بالتعاسة بدون سبب ؟ | لا | نعم |
| ٨ - هل حدث في أى موقف أن كنت جشع (طماع) فأخذت لنفسك من أى شيء أكثر مما يخصك ؟ | لا | نعم |
| ٩ - هل تفلق بيتك بعناية في الليل ؟ | لا | نعم |
| ١٠ - هل أنت أقرب إلى الحيوية ؟ | لا | نعم |
| ١١ - هل يضايقك كثيرا أن ترى طفلا أو حيوانا يتعذب ؟ | لا | نعم |
| ١٢ - هل تقلق في كثير من الأحيان على أمور لم يكن يصح أن تفعلها أو تقولها ؟ | لا | نعم |
| ١٣ - إذا وعدت بأن تعمل شيئا ، فهل تحافظ دائما على وعدك بها يكن ذلك متعبا لك ؟ | لا | نعم |
| ١٤ - هل تحب القفز بالمظلات من الطائرة ؟ | لا | نعم |
| ١٥ - هل تنطلق مادة وتنتع نفسك إذا ذهبت إلى حفلة مرحة ؟ | لا | نعم |
| ١٦ - هل أنت تنترفز بسهولة ؟ | لا | نعم |
| ١٧ - هل حدث أن ألقىت اللوم على شخص آخر لخطأ كنت تعرف أنك المسئول الحقيقي عنه ؟ | لا | نعم |
| ١٨ - هل تستمتع بلقاء أشخاص لم تكن تعرفهم من قبل ؟ | لا | نعم |
| ١٩ - هل تعتقد أن التأمين على الحياة أو الممتلكات فكرة جيدة ؟ | لا | نعم |
| ٢٠ - هل تفرح مشاعرك بسهولة ؟ | لا | نعم |

- نعم لا ٢١- هل كل عاداتك حسنة ومحبية ؟
- نعم لا ٢٢- هل تميل لأن تبقى بعيدا عن الأضواء في المناسبات الاجتماعية ؟
- نعم لا ٢٣- هل يمكن أن تأخذ عقاقير أو مركبات قد يكون لها آثار غريبة أو خطيرة ؟
- نعم لا ٢٤- هل تشعر غالبا بألك زمكان (طهقان) ؟
- نعم لا ٢٥- هل حدث أن أخذت شيئا (حتى ولو كان دبوس أو زرار) يخص شخصا آخر ؟
- نعم لا ٢٦- هل تحب الخروج كثيرا ؟
- نعم لا ٢٧- هل تستمتع بإيذاء من تحب ؟
- نعم لا ٢٨- هل يضايقك في أغلب الأحيان الشعور بألك عملت ذنب ؟
- نعم لا ٢٩- هل يحدث أحيانا أن تحكم عن أشياء أو موضوعات لا تعرفها ؟
- نعم لا ٣٠- هل تفضل القراءة أكثر من مقابلة الناس ؟
- نعم لا ٣١- هل لك أعداء يريدون إيذاءك ؟
- نعم لا ٣٢- هل تعتبر نفسك شخص عصبي ؟
- نعم لا ٣٣- هل تعتذر دائما عندما تتصرف تصرفا غير مهذب ؟
- نعم لا ٣٤- هل لك أصدقاء كثيرون ؟
- نعم لا ٣٥- هل تستمتع بعمل مقابل في الآخرين قد تؤذيهم في بعض الأحيان ؟
- نعم لا ٣٦- هل أنت شاكيل المهم باستمرار ؟
- نعم لا ٣٧- عندما كنت طفلا هل كنت تنفذ ما يطلب منك فورا ودون تذمر ؟
- نعم لا ٣٨- هل تعتبر نفسك شخص محبوب وما تشيلش ؟
- نعم لا ٣٩- هل العادات الحميدة والنظافة لها أهمية كبيرة عندك ؟
- نعم لا ٤٠- هل تقلق على ما يحتمل أن يحدث من أمور سيئة ؟
- نعم لا ٤١- هل حدث أن كسرت أو ضيقت شيئا يمتلكه شخص آخر ؟
- نعم لا ٤٢- هل تبادر أنت عادة بالتعرف على أصدقاء جدد ؟
- نعم لا ٤٣- هل تستطيع أن تفهم بسهولة مشاعر الآخرين عندما يكلمونك عن متاعبهم ؟
- نعم لا ٤٤- هل تعتبر نفسك متوتر أو سهل الاستثارة ؟
- نعم لا ٤٥- هل تلي الأوراق المستهلكة على الأرض عندما لا تكون هناك سلة مهملات ؟
- نعم لا ٤٦- هل تكون في الغالب صامتا وأنت مع أشخاص آخرين ؟
- نعم لا ٤٧- هل تعتمد أن الزواج موضحة قديمة ويجب إلغاؤه ؟

- ٤٨ - هل تصعب عليك نفسك من حين لآخر ؟ نعم لا
- ٤٩ - هل تتفاخر بنفسك قليلا من حين لآخر ؟ نعم لا
- ٥٠ - هل يمكنك بسهولة أن تدخل الحيوية على حفلة مملة ودعها ثقيل ؟ نعم لا
- ٥١ - هل يضايقك الذين يقودون سياراتهم بحرص شديد ؟ نعم لا
- ٥٢ - هل تهلق على صحتك ؟ نعم لا
- ٥٣ - هل حدث أن قلت شيئا سيئا أو قبيحا على أى شخص ؟ نعم لا
- ٥٤ - هل تحب أن تقول نكت وحكايات مسلية لأصدقائك ؟ نعم لا
- ٥٥ - هل تستوى في نظرك معظم الأمور بحيث تجد أن لها طعم واحد ؟ نعم لا
- ٥٦ - هل تشعر بأنك مكبوس أحيانا ؟ نعم لا
- ٥٧ - عندما كنت طفلا ، هل حدث مرة أن كنت متبجحا مع والديك ؟ نعم لا
- ٥٨ - هل تحب الاختلاط بالناس ؟ نعم لا
- ٥٩ - هل تشعر بالقلق إذا عرفت أن هناك أخطاء في عملك ؟ نعم لا
- ٦٠ - هل تعاني من قلة النوم ؟ نعم لا
- ٦١ - هل تفصل يدك دائما قبل الأكل ؟ نعم لا
- ٦٢ - هل يكون لديك في معظم الأحيان إجابة جاهزة عندما يكلمك الآخرون ؟ نعم لا
- ٦٣ - هل تحب أن تصل قبل مواعيدك بوقت كاف ؟ نعم لا
- ٦٤ - هل تشعر غالبا بالتعب والإرهاق بدون سبب ؟ نعم لا
- ٦٥ - هل حدث مرة أنك غشيت في أى لعبة أو مباراة ؟ نعم لا
- ٦٦ - هل تحب أن تعمل الأشياء التي تحتاج إلى السرعة في أدائها ؟ نعم لا
- ٦٧ - هل والدتك ست طيبة ؟ نعم لا
- ٦٨ - هل تشعر غالبا بأن الحياة مملة جدا ؟ نعم لا
- ٦٩ - هل حدث أن استغليت أى شخص ؟ نعم لا
- ٧٠ - هل تتعهد غالبا بالقيام بأعمال أكثر مما يتسع له وقتك ؟ نعم لا
- ٧١ - هل هناك أشخاص كثيرون حريصون على أنهم يتجنبونك ؟ نعم لا
- ٧٢ - هل تقلق كثيرا على مظهرك ؟ نعم لا
- ٧٣ - هل أنت مهذب حتى مع الأشخاص السخفاء ؟ نعم لا
- ٧٤ - هل تعتقد أن الناس يضيعون وقتا كثيرا في حماية مستقبلهم بعمليات الإخبار والتأمين ؟ نعم لا

- ٧٥ - هل حدث أن تمنيت لو كنت ميتا؟ نعم لا
- ٧٦ - هل تهرب من الضرائب لو تأكدت أنك لن تضبط إطلاقا؟ نعم لا
- ٧٧ - هل يمكنك أن تحافظ على استمرار حيوية حفلة؟ نعم لا
- ٧٨ - هل تحاول ألا تكون وقحا مع الناس؟ نعم لا
- ٧٩ - هل تقلق لمدة طويلة جدا بعد مرورك بخبرة مخجلة؟ نعم لا
- ٨٠ - هل حدث أن أصريت في أي موقف على أن تتصرف بطريقتك الخاصة؟ نعم لا
- ٨١ - عندما تريد السفر بالتطار فهل تصل غالبا في آخر دقيقة؟ نعم لا
- ٨٢ - هل تعاني من الأعصاب؟ نعم لا
- ٨٣ - هل تعمدت أن تقول شيئا لجرح مشاعر أحد؟ نعم لا
- ٨٤ - هل تكره أن تكون في جماعة من الناس يعملوا مقابل بريئة بعضهم في بعض؟ نعم لا
- ٨٥ - هل تنهار صداقتك بسهولة دون أن تكون أنت السبب؟ نعم لا
- ٨٦ - هل تشعر غالبا بالوحدة؟ نعم لا
- ٨٧ - هل تفعل غالبا ما تنصح به غيرك؟ نعم لا
- ٨٨ - هل تحب أن تعاكس الحيوانات أحيانا؟ نعم لا
- ٨٩ - هل تجرح مشاعرك بسهولة عندما يجد الناس فيك أو في عملك عيب أو خطأ؟ نعم لا
- ٩٠ - هل تصبح الحياة مملة بالنسبة لك إن لم يكن فيها أخطار؟ نعم لا
- ٩١ - هل حدث مرة أن تأخرت عن موعد أو عن عمل؟ نعم لا
- ٩٢ - هل تحب أن تتمد الكثير من الميصة والإثارة من حولك؟ نعم لا
- ٩٣ - هل تحب أن يخاف منك الآخرون؟ نعم لا
- ٩٤ - هل تكون أحيانا مليئا بالنشاط وأحيانا أخرى خاملا جدا؟ نعم لا
- ٩٥ - هل تؤجل أحيانا عمل اليوم إلى الغد؟ نعم لا
- ٩٦ - هل يراك الآخرون على أنك مليء بالحيوية والنشاط؟ نعم لا
- ٩٧ - هل يكذب عليك الناس كثيرا؟ نعم لا
- ٩٨ - هل أنت حساس من ناحية بعض الأمور؟ نعم لا
- ٩٩ - هل أنت مستعد دائما للاعتراف بالخطأ إذا صدر عنك؟ نعم لا
- ١٠٠ - هل تشعر بحزن شديد على حيوان وقع في مصيدة؟ نعم لا
- ١٠١ - هل ضايقتك أنك تجاوب على هذه الاسئلة؟ نعم لا

APPENDIX 15

GHQ Sheffield Sample

Table of means

Grand mean	22.833
Exp	21.758
Cont	23.909
Admiss	37.227
Discharge	12.000
Post discharge	19.273
Exp admiss	39.909
Exp discharge	08.727
Exp post discharge	16.636
Cont admiss	34.545
Cont discharge	15.273
Cont post discharge	21.909

Analysis of variance summary table

Source of Variation	DF	Sum of squares	Mean square	F-Ratio
Between subjects total	21	9560.500		
Group	1	76.379	76.379	0.161
Residual	20	9484.121	474.206	
Within subjects total	44	12958.667		
Behave	2	7418.939	3709.470	29.270
Group behave	2	470.394	235.197	1.856
Residual	40	5069.333	126.733	
Sub-total	44	12958.66		
Grand total	65	22519.167		
Behav linear trend	1	3546.023	3546.023	27.980
Behav quadratic trend	1	3872.917	3072.917	30.560

APPENDIX 16

BAI₃₀ Sheffield Sample

Table of means

Grand mean	112.152
Exp	114.303
Cont	110.000
Admiss	92.591
Discharge	118.182
Post discharge	125.682
Exp admiss	90.364
Exp discharge	119.364
Exp post discharge	133.182
Cont admiss	94.818
Cont discharge	117.000
Cont post discharge	118.182

Analysis of variance summary table

Source of Variation	DF	Sum of squares	Mean square	F-Ratio
Between subjects total	21	9725.818		
Group	1	305.515	305.515	0.649
Residual	20	9420.303	471.015	
Within subjects total	44	19720.667		
Behave	2	13245.121	6622.561	49.022
Group behave	2	1071.848	535.924	3.967
Residual	40	5403.697	135.092	
Sub-total	44	19720.667		
Grand total	65	29446.485		
Behave linear trend	1	12045.091	12045.091	89.162
Behave quadratic trend	1	1200.030	1200.030	8.883

APPENDIX 17

EPI Sheffield Sample

T-test (independent samples)

Ext 1 Extrav 1 by Ext 2 Extrav 2

	Ext 1	Ext 2
Mean	9.909	9.182
Variance	13.091	11.164
No cases	11.000	11.000

T = 0.490 with 20 degrees of freedom

T-test (independent samples)

Neur 1 Neurot 1 by Neur 2 Neurot 2

	Neur 1	Neur 2
Mean	16.636	14.273
Variance	15.455	16.618
No cases	11.000	11.000

T = 1.384 with 20 degrees of freedom

T-test (independent samples)

Lie 1 Lies 1 by Lie 2 Lies 2

	Lie 1	Lies 2
Mean	2.727	3.182
Variance	1.818	2.564
No cases	11.000	11.000

T = 0.720 with 20 degrees of freedom

APPENDIX 18

GHQ Cairo Sample

Table of means

Grand mean	11.241
Exp	11.519
Cont	10.963
Admiss	19.000
Discharge	8.444
Post discharge	6.278
Exp admiss	19.222
Exp discharge	10.444
Exp post discharge	4.889
Cont admiss	18.778
Cont discharge	6.444
Cont post discharge	7.667

Analysis of variance summary table

Source of Variation	DF	Sum of squares	Mean square	F-Ratio
Between subjects total	17	1196.537		
Group	1	4.167	4.167	0.056
Residual	16	1192.370	74.523	
Within subjects total	36	2697.333		
Behave	2	1167.815	833.907	28.815
Group behave	2	103.444	51.722	1.787
Residual	32	926.074	28.940	
Sub-total	36	2697.333		
Grand Total	53	3893.870		
Behave linear trend	1	1456.694	1456.694	50.335
Behave quadratic trend	1	211.120	211.120	7.295

APPENDIX 19

BAI₃₀ Cairo Sample

Table of means

Grand mean	119.296
Exp	121.259
Cont	117.333
Admiss	105.444
Discharge	122.778
Post discharge	129.667
Exp admiss	106.556
Exp discharge	122.556
Exp post discharge	134.667
Cont admiss	104.333
Cont discharge	123.000
Cont post discharge	124.667

Analysis of variance summary table

Source of Variation	DF	Sum of squares	Mean square	F-Ratio
Between subjects total	17	5535.259		
Group	1	208.074	208.074	0.625
Residual	16	5327.185	332.949	
With subjects total	36	10484.000		
Behave	2	5607.704	2803.852	19.457
Group behave	2	265.037	132.519	0.920
Residual	32	4611.259	144.102	
Sub-total	36	10484.000		
Grand total	53	16019.259		
Behave linear trend	1	5280.444	5280.444	36.644
Behave quadratic trend	1	327.259	327.259	2.271

APPENDIX 20

EPI Cairo Sample

T-test (independent samples)

Ext 1 Extrav 1 by Ext 2 Extrav 2

	Ext 1	Ext 2
Mean	10.333	10.444
Variable	25.000	34.528
No cases	9.000	9.000

T = 0.043 with 16 degrees of freedom

T-test (independent samples)

Neur 1 Neurot 1 by Neur 2 Neurot 2

	Neur 1	Neur 2
Mean	17.444	16.222
Variance	25.028	29.694
No cases	9.000	9.000

T = 0.496 with 16 degrees of freedom

T-test (independent samples)

Lie 1 Lies 1 by Lie 2 Lies 2

	Lie 1	Lies 2
Mean	14.889	15.000
Variance	29.361	23,250
No cases	9.000	9.000

T = 0.046 with 16 degrees of freedom

APPENDIX 21

BRIEF CASE STUDY

Personal Information: (source hospital records and patient)

Patient's Name: Ronald Black
Age: 31 (1983)
Sex: Male
Marital Status: Single
Occupation: Unemployed (used to work as a teacher of theology)
Diagnosis: Paranoid schizophrenia
Admission: Acute (history of repeated admissions)
Date of admission: April 1983
Date of discharge: June 1983
Period of follow-up: 6 months

Presenting picture (source: hospital record and psychiatric consultant)

Troubled by feelings of persecution by the CIA, ideas of reference, auditory hallucinations, and his family, especially his mother, cannot cope with his illness.

Family and social background

Ronald is descended from a well-off family, his father is a headmaster and has brought him up by firm moral standards. On the other hand his mother is submissive and lenient, giving shelter to Ronald to escape his father's dogmatism. Ronald has one sister and no brothers. His sister teaches English and is married to an Iranian. According to the consultant, his inconsistent family relations resulted in Ronald's psychiatric disturbance and his sister married a foreigner to escape this family situation.

Work: Used to work as a teacher of theology, five years ago, currently unemployed
Religion: He believes in the Church of England form of faith and considers himself to be a very religious person; he wants to work as a priest as he deserves to be a servant of God.

Development of the problem (source: patient and psychiatric consultant)

Ronald's symptoms started 5 years ago, following a mysterious incident of being imprisoned for "one night" for no clear reason.

He began to feel persecuted by agents of the CIA, being drugged by them and that they would prevent him from going anywhere in the world (his applications for immigration to Australia, Canada and Israel were refused). He believed the CIA was responsible for the killing of some of

his friends in Syria (who belonged to a certain organisation and had been tortured). As a result of these ideas he became very suspicious, mistrusted everyone, was unable to maintain any social relationship or have a girlfriend.

BAI assessment on admission

BAI scores were below 4 on the following items:

Nos 1, 2, 5, 7, 9, 10, 14, 15, 17, 18, 22, 23, 26, 27, 29

These items were presented by the following features:

1. Inability to maintain relaxed posture, muscle tension in arms and legs during the presence of strangers
Never starts communication with anybody
Does not answer probing questions
Withdrawn from the rest of the patients
Very polite, does not allow himself to be firm or say 'no' to others
Blames others for his misfortune
Items: 1, 2, 5, 7, 8, 9
2. Refuses to discuss his feelings except with his consultant
Misinterprets different incidences (ideas of reference)
Unable to appraise his problems realistically (feelings of persecution)
Lacks self confidence, feels over-ruled by his father
Wants to be dependent on the family
Unable to establish a working relationship with a girl friend
Items: 10, 14, 15, 17, 18
3. Needs instructions to pursue self-care. Loses weight because of his suspicions. Drinks fluids with a straw.
Lacks skills of cooking, shopping or looking after himself and family affairs.
Insecure relationship with his parents. Unemployed.
Items: 22, 23, 26, 27, 29

Plan of work

1. Encourage independence and teach him necessary domestic skills to help him gain independence
2. Encourage him to mix with other patients through different activities (busking, going to the cinema, to pubs etc)
3. Involve him in some group therapies to gain more insight about his illness and to learn to trust other therapists
4. Plan for discharge and community follow-up

Hospital Intervention

Both medical and psychosocial models were incorporated in this case. The hospital decided to keep him for 6-8 weeks where the previous types of therapies were implemented + chemotherapy (Stelazine 15 mg) 3 times a day. Discharge to a halfway house with intensive support in the community from the researcher, the social worker and continuation of the OT programme in the Day hospital.

Researcher intervention

- 1 Incorporated with the hospital plan, participation in activities and daily OT programmes.
- 2 Individual therapy session for the purpose of developing mutual trust, therapeutic relationship and provision of supportive psychotherapy
- 3 Follow-up in the community with intensive support and guidance

Involvement of his social worker was necessary

Intervention Diary

1st session:	Admission - 2nd week of April 1983
Interview:	Psychiatric consultant with the patient and his father
Problems identified:	RB developed psychotic symptoms again, does not sleep or eat, lost weight, looks exhausted. His mother is extremely anxious about his condition
Intervention:	Hospitalisation for a period of 6-8 weeks. Control of symptoms by phenothiazines. Involve him in some group therapies.
Evaluation and outcomes:	Patient welcomed admission as he believes that the CIA can reach him anywhere except in the hospital
2nd session:	3rd week of April 1983
Interview:	NM with RB
Intervention:	NM introduced herself to the patient, talked about some of the problems (being drugged). Refused to talk about his family relations. Asked him to participate in the research project and to fill in the questionnaire forms
Items:	1, 2, 5, 7, 9, 10, 14, 16, 17, 18, 22, 23, 26, 27, 29
Evaluation:	RB does not trust the researcher, however, he behaved very politely and talked in a low voice Agreed to fill in the forms
3rd session:	4th week of April
Interview:	RB with NM
Problems:	Mistrusts people, has no girl friend, feels lonely, persecuted by CIA agent
Intervention:	Encourage him to talk freely about his problems Discuss his views regarding these problems Encourage him to join the social skills group in the Day Hospital
Items:	1, 2, 5, 10, 14, 17, 18
Evaluation:	Patient was surprisingly open about his feelings towards females and that he wants to marry to escape loneliness. Agreed to join social skills group.

4th session: 4th week of April (same week)
 Interview: RB with NM and another female patient
 Problems: As before
 Intervention: Introduce him to a female patient on the ward who shared with him the hobby of playing the guitar
 Ask them to play jointly to patients on the ward over the weekend
 Items: 7, 9, 18
 Evaluation: Both agreed to the suggestion and spent much time training together. The trial was successful and the patients on the ward enjoyed it.
 The suggestion for another joint session was refused as neither RB nor the other patient have anything new to play

5th session: 1st week of May 1983
 Interview: RB with NM on the ward round
 Problems: As above + lack of domestic skills
 Intervention: Involved him in some therapeutic activities such as lunch-time cookery and poetry
 Involve him in some therapeutic activities of indirect self-expressive nature eg art therapy
 Items: As before + 22, 23
 Evaluation: RB agreed to the plan and joined in

6th session: 2nd week of May 1984
 Interview: RB with NM
 Problems: As before + started to have difficulty in swallowing fluids
 Intervention: Listen to his complaint about his throat problems
 Encourage him to report to the resident Doctor
 Encourage him to join the ward outings
 Items: As before
 Evaluation: RB drinks fluids with a straw, believes that the CIA has drugged him through the smoke of his cigarettes
 He reported it to the ward registrar who gave him penicillin tablets
 RB went to the cinema with a ward outing.
 Refused to go to the pub as he cannot drink with a straw. However, the suggestive TR did succeed in making him swallow better.

PS The individual sessions were very short, usually 15-30 minutes as the patient's tolerance and span of attention was low. Group activities and other indirect forms of therapy were very useful to him, especially art therapy. His domestic skills improved and he agreed to move to a halfway house on discharge from hospital. His social worker arranged for him to go there and for him to receive disability pension (ie better payment).

Community follow up

7th session: 2nd week of June 1983
Interview: RB with NM at the Halfway House
Problems: RB is desperate for work as a priest or theological teacher. Applied for 16 posts, not heard anything. Does not have a reference; not a very good idea to give the name of his consultant as a referee. Swallowing problem still troublesome.
Intervention: Encourage him to discuss this problem with his social worker
Encourage him to continue with his OT programmes at the Day hospital
Encourage him to develop some social relationships with people at the halfway house (5 persons are sharing, 2 women and 3 men).
Items: As before
Evaluation: Claimed feeling happy being out of the hospital and enjoys independence.
His throat problem improved and started to drink slowly without a straw.
He was able to participate in cooking and shopping and preparing simple meals for himself and housemates

8th session: 1st week of July
Interview: RB with NM at the Halfway House
Problems: Urgent call from RB to NM at the hospital, feels persecuted again, drugged and could not sleep all night
Intervention: Immediate visit to RB at the halfway house
Discussion focused on:
1 Regularity of taking his medication
2 Degree of disturbance caused by his feelings and thoughts
3 Reason for this event (RB explained that a new resident has moved to the halfway house and that he is suspicious of him)
4 The reason for these feelings and what he wants to do to solve the problem
5 RB's suggestion to go home for a week was refused
6 Problem of trusting others was discussed in detail. Another resident acceptable to RB took part in the discussion
7 The new resident (subject of the suspicion) was later on asked to introduce himself to us
Item: 7, 14, 17
Evaluation: RB was open about his feelings, his strategy was to escape again from the problem. He agreed that his inability to trust others was handicapping him socially.
He claimed that he partly trusted me and named a few other people he could trust.
The presence of the other resident (whom RB accepts) was very helpful as it decreased RB's anxiety and determination to go home.

9th session:	1st week of July - the following day
Interview:	RB with NM at her office in the hospital
Problems:	RB is still feeling very tense because of DA (the new resident) as cannot trust him. Feelings of persecution and being drugged are less strong. He was able to get some sleep the previous night.
Intervention:	Encourage him: <ul style="list-style-type: none"> - to talk to DA so he will get to know him better - to attend regularly the yoga class and anxiety management in the day hospital His suggestion to go home for a week-end was accepted with the consultant's permission
Items:	As before
Evaluation:	RB accepted the suggested plan His parents were not ready to receive him that weekend but agreed to him visiting them on the following weekend
10th session:	2nd week of July
Interview:	RB with NM and PS at the hospital
Problems:	Trusting other people Lack of social skills Family relations Unemployment
Intervention:	Encourage RB to find out why he does not trust people and whom he is most suspicious of Encourage him to join the ward outings, to be less lonely Encourage him to do some voluntary work, and to start busking in the city centre to get some extra money
Items:	15, 17, 27, 29
Evaluation:	Again RB agreed to the plan but did not do anything except join an outing to the cinema (ward outing)
11th session:	1st week of August 1983
Interview:	RB with PS and NM
Problems:	As before + his parents and his consultant are away on holiday Feelings of persecution were great and he wanted to be admitted to the hospital Does not look after his personal hygiene
Intervention:	Arrange for him to have an appointment with another psychiatrist who is in charge He was prescribed modicate (long acting) injection Encourage him to attend OT programme regularly and not to insist on coming to hospital; also to pursue self care
Items:	7, 14, 17
Evaluation:	RB agreed to the injection treatment and asked to have a less intensive OT programme, instead of 3 days per week, 2 days per week would be enough This was arranged for him

12th session: 2nd week of August 1983
Interview: RB with NM and PS (his social worker)
Problems: Unemployment
Intervention: PS found him a job on a voluntary basis as an English teacher for illiterates in a nearby Community Day Centre
PS took RB to show him the centre and introduced him to the people there
Items: 29
Evaluation: RB accepted the job at first for two weeks, then he refused to continue

13th session: 4th week of September
Interview: RB with NM
Problems: Unemployment
Intervention: Discussion focused on:
- what he wants to do
- Reasons for leaving the voluntary work
- what is his plan to find a job
Items: 29
Evaluation: RB applied for several jobs advertised and applied to go on a course for teaching English as a foreign language

PS RB's condition was more or less stable, apart from a few episodes of feeling persecuted and drugged.
He agreed to stay in the halfway house, regularly attending the Art therapy sessions and Yoga classes. He was able to visit his family from time to time
Accepted the difficulty of trying to find a job, requested the consultant help him to find a job as a priest.

Termination of the follow-up took place at this stage, November 1983

Researcher impression and analysis

Ronald suffered psychotic symptoms which benefited most from the chemotherapy. However, the researcher accepted the challenge of implementing the psychosocial model for his condition, hoping to minimise his recurrent admissions to the hospital with every episode.

Ronald was unable to trust anybody except his consultant, who was to him a strong, welcoming father figure, who could protect him from the CIA. This could explain why Ronald used to feel secure only in the hospital.

The therapeutic team agreed to help Ronald towards independence and the plan of care followed from there.

Many constraints faced the researcher with Ronald's case eg being a chronic patient, he was conditioned to certain ways of treatment with certain people whom he knew. To trust the researcher needed a lot of time and effort. The researcher's attitude towards stopping Ronald from escaping difficult situations was not very welcome to him and dealing with the problem solely from the patient's side, not including his family as well, was not effective. (The parents were approached by the consultant but the father was not far away from change.)

In the light of the new experience gained by the researcher, a self criticism is that the implemented approach was not necessary to help Ronald as much as teaching him to conform to others' morals in society's norms.

BAI₃₀ Assessment score of Ronald's condition

Item No	Section	Statement	BAI Score		
			Admis- sion	Hosp dis- charge	End of follow- up
1	Communication and social skills	Non-verbal communication	2	5	4
2	"	Initiate conversation	1	2	4
5	"	Respond to questions	2	5	5
7	"	Live peacefully with others	1	1	4
9	"	Accept success/ failure	1	1	1
10	Insight	Discuss personal feelings	2	3	3
14	"	Realistic appraisal of current problems	1	3	3
15	"	Self confidence	1	2	4
17	"	Sensible in dealing with problems	2	2	4
18	"	Conventional interest in sex	2	4	4
22	Self and family care	Preparation of meals	1	2	2
23	"	Shopping trips	1	2	2
26	"	Manages everyday responsibilities	2	3	3
27	"	Deals with family problems	2	3	3
28	"	Seeks medical help	1	3	4
29	"	Work duties	1	2	1

APPENDIX 22
BRIEF CASE STUDY

Personal Information: Source: Hospital record

Patient's name: Rahmy Fahad

Age: 56 (1984)

Sex: Male

Marital Status: Married with 7 children

Occupation: Driver (for petroleum company in Red Sea area)

Diagnosis: Depressive situational disorder

Admission: Acute (first admission)

Date of admission: September 1984
Date of discharge: October 1984

Period of follow-up: 3 months

Presenting picture (Source: Hospital record and patient)

Semi-conscious, sad, weepy, inability to concentrate or hold a meaningful conversation

Family and Social History (Source: patient)

Rahmy came originally from Upper Egypt (South) and he kept to their social and family traditions (ie respect paid to older people, especially the father, who must approve of his childrens' future plans).

Rahmy came to work in Cairo; when he was 18 years old he learned to drive, got married and has worked for the same company since that time.

He has 7 children, 3 sons and 4 daughters, all of whom are now grown up and have attained different levels of educational achievement. He is proud of them since he did not achieve any educational level, being just capable of reading and writing Arabic.

Work: Satisfied with his work, well paid and good promotion

Religion: Islam

Faith: Believes in all Islam laws and rules. Believes in God, prays regularly and has visited Mecca, the Holy Place, twice.

Development of the Problem (Source: patient)

Rahmy's children are now grown up, the youngest being 16 years old. One of his daughters, who is 17 years old and studying at secondary school, ran away from home and got married to a neighbour who is already married with 4 children and who is twice her age. This behaviour was a great shock to Rahmy. He and his 3 sons had a fight with the neighbour, who used a knife to defend himself and injured one of Rahmy's sons. The situation was very complicated, Rahmy could not stand the stress and fell down unconscious. He was taken to the El-Neil Hospital where he was admitted.

The son's injury was only superficial and was treated in a general hospital.

BAI Assessment

BAI scores were below 4 on the following items:

Nos 1, 2, 7, 8, 9, 14, 17, 27, 30

These items were represented by the following features:

1. Tension in the face and hand muscles
Pre-occupied and needs motivating to start talking
Sometimes gets anxious and intrudes in a conversation
Does not give complete answers to questions
Withdrawn from other patients and hospital social environment
Became aggressive instead of assertive
Cannot accept the fact that his daughter decided to marry of her own free will
Believes that she was forced to do so

Items: 1, 2, 7, 8, 9

2. Used violent approach to deal with his problem instead of discussing the problem with the husband.
Unable to see or analyse the problem from other perspectives

Items: 14, 17

3. Lack of mutual understanding between him and his daughters
Preference for sons to daughters
Did not pursue any social activities but centred his life on arranging the lives of his family

Items: 27, 30

Plan of Work

1. Locate and identify the most distressful problems and feelings
2. Encourage the patient to let out his suppressed negative feelings
3. Help the patient to gain more insight into his behaviour
4. Prepare a plan with him for resolving his problems
5. Encourage him to start developing his social skills
6. Plan for discharge and follow-up phase

Hospital Intervention

Mainly chemical and medical check up to control diabetes which he had developed. He was put on anti-depressant and minor tranquillizer treatment. His condition and any improvement was assessed during the weekly ward rounds.

Researcher Intervention

- a) Join the ward rounds, discuss his condition and review the care plan
- b) Individual therapy, joint sessions with the consultant
Insight and supportive psychotherapy approaches were used
Sessions were on a weekly basis during hospitalisation and every other week during the community follow-up. The follow-up sessions were held at the patient's house.

Intervention Diary

1st session:	Admission - 1st week of September 1984
Interview:	Hospital Resident Dr with the patient's son and wife
Problems identified:	Patient sad and weepy, semi-conscious, depressed following the development of his family problem Diabetes was diagnosed
Intervention:	Safe hospital environmental observation No visitors for the first week Regular hospital medical check ups
Evaluation:	Patient very depressed, in need of psychological help
2nd session:	2nd week of September
1st interview	RF with consultant and NM
Problems	Very depressed, feeling hurt, disbelief at his daughter's behaviour, threat to his honour, worry about his social image, preoccupied, limited awareness of how his behaviour could have helped the problem develop. Feeling of grief at losing his daughter Still feeling angry about his daughter's behaviour and so decided to reject her from the family and from his care Regrets using violence to solve the problem
Items:	1, 2, 7, 8, 9, 14, 17, 27, 30
Intervention:	Encourage Rahmy to talk about the problem, how it began, his feelings, analysis and comments about different aspects of the problem Discuss with him the legal aspect of the problem, suggest obtains legal help Explain briefly to the patient the purpose of the research and what help could be offered if would co-operate. Carried out BAI assessment
Evaluation:	Patient welcomed co-operation and filled in the questionnaire forms with some assistance Patient was tearful when talking about his family problem and manifested stress and tension in his face and hand muscles He agreed to the psychotherapy plan

3rd session: 3rd week of September
 2nd interview: RF with consultant and NM
 Problems: As before
 Items: 1, 2, 14, 17, 27
 Intervention: Discussion focused on localising and identifying the most painful feelings
 Encourage him to talk about it in detail
 Help him to try to adjust and cope with his pain and learn new concepts in everyday modern life
 Evaluation: Patient identified the following as main problems:

- a) He behaved in a violent way and forgot 'Allah' and Islamic rules
- b) His own son was injured and could have been killed which would have made his loss even greater and unbearable
- c) He had lost his daughter and her behaviour had shamed his social honour

4th session: 4th week of September
 3rd interview: RF with consultant and NM
 Problems: Patient's concept of his role in the family (believes that it is his role to be responsible for the planning of the present and future life of each member of his family)
 His feelings of pain, agony, grief and loss of social honour
 Feelings of regret for previous violent behaviour
 Items: 7, 8, 9, 14, 17, 27
 Intervention: Encourage the patient to analyse, criticise and explore the underlying reasons for his violent behaviour and to accept the situation, to find some excuse for his daughter's behaviour
 Discuss with him the researcher's controversial point of view
 Acknowledge his feelings of being hurt, his lost honour (discussed with him the fact that his daughter had married before running away, so she was not behaving in a way which would reflect dishonour on him)
 Evaluation: Patient was perceptive, accepting the opposite view points, and tried to accept the situation and that he could not change anything at present.
 He was convinced that violence had only harmed him and his family and would never solve the problem
 He promised to try to excuse his daughter's behaviour and to begin coping with his painful feelings by praying to God and to become less worried, more understanding
 Became less tense

5th session: 1st week of October
 4th interview: RF with consultant and NM
 Problems: Discharge from hospital
 Threat to social image (psychiatric patient)
 Follow-up plan and home visit
 Returning to work and being away from Cairo and his family at this stage
 Items: 9, 27, 29, 30

Intervention: Explore the patient's feelings, future plan and coping mechanisms regarding his discharge
Avoid discussing the problem of his daughter and acknowledge his efforts to cope
Hospital granted him 3 weeks' sick leave

Evaluation: Patient was relaxed about his discharge
Welcomed the planning for the home visits and follow-up
Received visits from friends and neighbours who were very supportive
Ready for discharge

6th session: 2nd week of October

5th interview: RF, his wife, one son and his family with NM
(first home visit, patient's house)

Problems: Patient perceived the visit as a social one
No discussion of any problems, only social talk

Items: 27

Intervention: Explore the situation, meet members of the family
Check that Rahmy is coping all right

Evaluation: Patient was coping very well, cheerful and sociable
Family support was of great help; they continued to treat him as head of the family and the person responsible for their lives
This helped give him confidence

7th session: 4th week of October

6th interview: RF, his wife, two daughters with NM

Problems: Preference for sons to daughters
Lack of communication between the elder daughter (21 years) and her parents
Restriction of the daughters' freedom following the running away of their sister (revealed by the elder daughter)
Lack of information about the control of diabetes

Items: 8, 9

Intervention: Interview with the elder daughter, requested by Rahmy who was worried by her noticeable weight loss
Health education about the diabetic problem, methods of control
A diabetic dietary plan was outlined for him and his wife

Evaluation: The daughter is feeling bitter about the way she is treated by her parents and brothers because they do not behave in a modern way as they pretended
The escape of her sister has ruined their family life and they are still bitter about this, all of them miss her but avoid talking about her and do not mention her name
They look cheerful to maintain social respect
The daughter is afraid that nobody would want to marry her after what her sister has done
Her feelings and fears were acknowledged and support was provided
The dietary plan for diabetes proved useful

8th session: 2nd week of November

7th interview: RF, his wife, with NM - later the daughter with NM

Problems: Diabetes problem now under control
Stopped taking the psychotropic medication (antidepressant and minor tranquillisers)
Unaware of the difficulties in his relationship with his daughters

Items: 27, 28

Intervention: Check Rahmy's physical and emotional health
 Advise him to see a psychiatric doctor before finishing with his medication altogether
 Check that he did cope with health problems while he was at work
 Discuss with him his relations with his daughters and help him to understand their feelings
 Have an individual session with the daughter and plan with her methods of coping and gradually changing
 Advise her also to receive some psychotherapy treatment from a psychiatrist to help her with her depression problem
 Explain to Rahmy and his wife their daughter's need for therapy
 Refer her to the consultant

Evaluation: Rahmy was coping very well, tried to improve his relationship with his daughter by buying her a few things
 No identified problem at work
 Accepted that his daughter needed psychotherapeutic help
 The daughter wanted to continue with the therapy provided by the researcher

9th session: 4th week of November

8th interview: Rahmy's daughter with NM on the phone

Problems: As before

Items: As before

Intervention: Encourage her to talk to her father about things she does not like
 Encourage her to plan for her future, save money etc
 Encourage her to become more tolerant of the family situation and the restrictions over her movements
 Advise her to regulate her dietary habits and not to eat too much spiced food

Evaluation: The daughter agreed to try and carry out these instructions

10th session: 2nd week of December

9th interview: RF, his youngest son, with NM at the hospital

Problems: No new problems identified

Items: 27, 30

Intervention: Brief meeting with RF and his son to ensure that he is coping all right without taking any psychotropic medication

Evaluation: Patient lost some weight but was coping all right and in good health
 Was carrying out his work duties and family responsibilities

11th session: 1st week of January 1985

10th interview: Rahmy's daughter with NM on the phone

Problems: As before

Items: As before

Intervention: Discuss and explore the different dimensions of her emotional problem
 Allow her to talk about her feelings
 Advise her to get professional help from the consultant as the researcher could not afford the time to deal with this problem

Evaluation: The daughter was uncertain about her feelings
 She was horrified in case any of her brothers should find out about her emotional relationship with one of her colleagues at work
 She needed guidance and support

12th session: 3rd week of January
 11th interview RF, his family, with NM (last home visit)
 Problems: Discharge from the follow-up
 Daughter refused to go to the consultant
 Visit atmosphere was more social than professional
 Items: 27
 Intervention: Advise the daughter to get some professional help
 Final assessment of Rahmy's condition
 Advise Rahmy and his wife to show they are as proud of their daughter as they are of their sons
 Evaluation: The daughter decided to go to the occupational health doctor at work. Rahmy and his wife welcomed all the advice given to them
 Rahmy filled in the questionnaire forms
 Follow-up phase terminated

Researcher analysis and impression

Rahmy's social and cultural background was the underlying factor of his aggressive behaviour towards his son-in-law. The negative feelings were very painful, therefore, at first he denied the intention of his daughter's behaviour, then he suppressed these feelings and looked sad.

The shock and shame had affected the whole family, especially the daughter who had to suffer the consequences of her sister's behaviour.

Rahmy is a very affectionate person but he did not show this to his daughters: he always spoke proudly of his sons but never spoke about his daughters in the same way.

His absence from the house for 14 days every month gave his sons the opportunity to abuse the daughters by treating them very badly, hitting them and restricting their movements. The daughters received little or no support from their mother who preferred boys to girls.

The situation was too difficult to change. Rahmy and his wife were advised to be more supportive of their daughters but the approach used was very gentle and indirect.

BAI 30 assessment score of Rahmy's condition

Item No	Section	Statement	BAI score		
			Admission	Hospital Discharge	Follow-up
1	Communication and social skill	Non-verbal communication	3	5	5
2		Initiate conversation	2	5	5
7		Live peacefully with others	3	5	5
8		Assertive when necessary	2	5	5
9		Accept success/failure	1	4	4
14	Insight	Realistic appraisal of current problems	3	3	5
17	"	Sensible in dealing with problems	2	5	5
27	Self and family care	Family problems	1	4	4
30	"	Hobbies and activities	3	4	5

APPENDIX 23

BRIEF CASE STUDY

Personal Information: Source Hospital Record

Patient's Name: Victoria Carr

Age: 32 (1983)

Sex: Female

Marital Status: Divorced

Occupation: Unemployed (at the time of hospitalisation), had worked as a domestic

Diagnosis: Paranoid schizophrenia

Admission: Acute

Date of Admission: July 1983

Date of Discharge: August 1983

Period of follow up: 4 months

Presenting Picture (Source: Hospital record and patient)

Excited, hearing voices, tried to kill herself - stopped by neighbour

Family and Social History

Vicky is black; she never saw or knew her father. She came as a baby with her mother from South Africa. Her mother married a black husband and had another 2 daughters and a son. She left the house and never came back and left her children to be brought up by this husband.

Vicky started to work as a prostitute when she was only 16 years old. This behaviour shamed her family who started to reject her.

Her step father married a white woman and had another son.

Vicky married a white man when she was 22 years old. Her marriage was successful and happy for 8 years but then it broke down. She had no children.

Work: Used to work as a domestic in shops and hospitals

Religion: Christian

Belief: Believes in God and that He is punishing her for her wrong behaviour in the past

Development of the Problem:

Vicky lives by herself in a flat in a block of flats; her sister, who is married, lives in the same block. However, Vicky spent much of her time alone, especially when she was unemployed. Started to hear voices, see shapes, feel persecuted, rejected and became very depressed and sorry about the loss of her happy married life. She became very bad tempered, used to get angry quickly and was unable to hold a job for very long. Finally, she tried to kill herself.

BAI₃₀ Assessment

BAI scores were below 4 on the following items:

Nos 1, 2, 7, 9, 14, 15, 16, 17, 19, 27, 28, 29 and 30

These items were represented by the following features:

1. Hallucinations (visual, auditory)
Delusions of persecution
Excitement
Suicidal attempts
Lack of self care

Items: 14, 17, 19, 28
2. Feelings of guilt, rejection, low self-confidence
Feelings of inferiority, sadness and sorrow

Items: 9, 15
3. Lack of social skills, no friends, fear of rejection
Lack of close family relations and support
Divorced

Items: 1, 2, 7, 27
4. Unemployment, boredom, loneliness
Lack of future plans, hobbies or activities

Items: 16, 29, 30

Plan of Work

1. Put patient under strict observation by her key worker and other ward nurses, regular medication, do not leave her alone for long periods
2. Encourage her to discuss her feelings. Listen to her, give her the chance to ventilate and express her negative feelings
3. Support her, convey acceptance and encourage her to see the positive side of herself and help her to gain some self confidence by doing useful things either for herself or for other patients
4. Encourage and develop her social skills, by joining social skills and communication groups, mixing with other patients participating in the hospital community, sharing in group activities and outings
5. Help with her family problems. Seek the assistance of the social worker in resolving the family problems as far as possible
6. Encourage her to apply for different jobs and give her letters of recommendation from the unit as required.

7. Prepare her for discharge, make a plan for the future with her and arrange for her to attend different group therapy in the day hospital and to attend a post-discharge group run by the researcher, social worker and some of the nurses from the hospital
8. Encourage and support her to practice the following activities:
 - a) hobbies such as knitting, cooking, reading and writing
 - b) join ward outings, visit her old friend with whom she feels more secure and less tense
 - c) visit her sister, family and neighbours

Hospital Intervention:

Chemotherapy ie anti-psychotic medication, group therapy and Day hospital services.

Researcher Intervention:

- a) Joined hospital treatment programme, co-operated with rest of staff members, made use of the hospital facilities
- b) Individual therapy based on the psycho-dynamic approach, supportive therapy and reality therapy

Sessions were held on a weekly basis during the hospitalisation period and then less frequently in the community follow up.

Follow up sessions were held at the patient's flat, an interview room in the hospital, or at Victoria Hall (a church in town at which post discharge group is held).

- c) Involvement of social worker where necessary.

Intervention Diary

1st session: Admission - first week of July 1983

Interview: Staff nurse on the ward
 Discussion focused on history - filling in the hospital record

Problems identified: Visual/auditory hallucinations, persecutory delusions, guilt feelings and suicidal tendency

Intervention: Observation, regular medication, safe environment

Outcome/Evaluation: Patient responded to questions, spoke about the voices she heard, showed evidence of lack of insight

2nd session: 2nd week of July 1983

Interview: 1st contact between VC and NM
 Got more details about case history and used BAI for assessment

Problems: As above + withdrawal behaviour

Items: 1, 2, 7, 9, 14, 15, 16, 17, 19, 27, 28, 30

Intervention: Explored patient's views about her illness, admission and her problems
 Explained to her the nature of the research work and the help she could get. Asked for her co-operation

Evaluation: Patient appeared to lack insight about the nature of her illness but

agreed to co-operate and filled in questionnaire forms

3rd session: 3rd week of July 1983

2nd interview: VC with NM

Problems: as before + feeling of rejection, sadness and sorrow at being divorced, feelings of inferiority and mistrust

Items: 2, 7, 9, 19

Intervention: Discussed the negative feelings, reasons for them and ways of resolving them
Encouraged her to explore the positive side of her life
Encouraged her to be in the company of other patients, encourage self care

Evaluation: Patient spoke about her painful feelings
Started to pay some attention to her appearance
Agreed to sit with other patients

4th session: 4th week of July 1983

3rd interview: VC with NM

Problems: As before + verbal aggression

Items: 1, 2, 7, 9

Intervention: Discussion focused on her feelings of anger. She had had a row with a patient who had hurt her feelings

Evaluation: Received acceptance and support

5th session: 1st week of August 1983

4th interview: VC with NM

Problems: as before + family problems (rejection)

Items: 14, 15, 16, 27

Intervention: Discussion focused on her feelings of guilt, self perception, origin of the family problem, ways of solving it

Evaluation: Patient accepted social worker involvement
Psychotic symptoms beginning to disappear

6th session: 1st week of August 1983

5th interview: VC with NM and PS (social worker)

Problem: Family rejection, fear of them, guilt and sorrow

Items: 15, 27

Intervention: Discussion focused on a working plan to resolve her family problem and gain their support

Evaluation: Patient agreed with the plan proposed by PS

7th session: 2nd week of August 1983

6th interview: VC with NM and PS

Problems: As before

Items: 2, 7, 15, 27

Intervention: Discussion focused on expression of her feelings, giving support, encouraging outings and mixing with other patients and regular attendance at therapy groups

Evaluation: PS got in touch with her step father who agreed to provide her with the necessary support
Joined the Craft group and started knitting

8th session: 3rd week of August 1983

7th interview: VC with NM and PS

Problems: Lack of social life, unemployment, discharge from hospital in 2 weeks' time

Items: 2, 27, 30
 Intervention: As before + help and encouragement to find a job
 Evaluation: Patient was visited by her stepmother and sister

9th session: 4th week of August 1983
 8th interview: VC with NM
 Problems: Job challenge, discharge, hospital stigma, difficulties with her social life
 Legitimate fears about how she would be received by her neighbours who had seen her previous aggressive behaviour

Items: 16, 17, 29, 30
 Intervention: Discussion focused on her anxieties and fears
 Plan for gradual discharge - to spend 2 nights at her flat before discharge
 (She was advised to spend short periods of time in her flat to start with and to approach her neighbours briefly and demonstrate her improvement to them.)
 Evaluation: Patient worried about her image as a psychiatric patient - support and reassurance were given

10th session: 4th week of August 1983 (same week)
 9th interview: VC with NM
 Problems: As before
 Items: 16, 17, 29, 30
 Intervention: Continue with the same plan
 Evaluation: Patient less worried, ready for discharge
 Promised to carry out post discharge plan

Community follow-up

11th session: 2nd week of September 1983
 Interview: VC and PS (NM on holiday)
 Feedback: Patient was coping all right, joined the day hospital group activities and post-discharge group etc. Took a part-time job as a cleaner in a book shop

12th session: 4th week of September 1983
 10th interview: VC with NM at her flat
 Problems: Limited social relationships with colleagues at work. Unpleasant feelings regarding her brother-in-law as he ignores her when she goes to visit her sister; also he prevents her sister from visiting her frequently
 Items: 15, 27, 29, 30
 Intervention: Analysis of her feelings towards colleagues and brother-in-law
 Helped to establish closer social relationships with people from the hospital
 Encouraged her to join her colleagues at work in their social evenings
 Evaluation: Patient was still over-sensitive about her colour and history of mental illness

13th session: 2nd week of October 1983
 11th interview: VC with NM at her work
 Problems: As before + wants to change her job; wanted a full time job in order to be better off
 Items: As before
 Intervention: Encouraged her to keep her current job and look for another.
 Provided her with some information about other job situations, asked her to seek help from PS

Evaluation: Her social relationships began to improve; she spent more of her free time with her sister, looked after the kids; but continued to avoid her brothers-in-law

14th session: 4th week of October 1983
 12th interview: VC with NM at the hospital
 Problem: Insufficient money earned, no longer attends group therapy
 Item: 29
 Intervention: Supported and accepted her decisions
 Evaluation: Patient seemed very happy and stable. Her other sister came over from Japan on holiday with her boyfriend. They were very good to Vicky, took her with them everywhere and filled her social life. Vicky gave up her part-time work to cope with her new social commitments

15th session: 2nd week of November 1983
 13th interview: VC at home with NM
 Problem: Need for a full time job
 Item: 29
 Intervention: As before + needed to check on medication
 Evaluation: As before + had a new boyfriend

16th session: 4th week of November 1983
 14th interview: VC at the hospital with NM
 Problems: Nothing urgent, not looking for a job
 Item: 29
 Intervention: Short visit to check on her stability
 Evaluation: Patient coping very well

17th session: 2nd week of December 1983
 15th interview: VC at her flat with NM
 Problem: Unhappy because her sister has returned to Japan
 Items: 29, 30
 Intervention: Encourage her to find a job and to mix with people at work and her boyfriend
 Evaluation: Patient is coping all right

18th session: 1st week of January 1984
 16th interview: VC at her flat with NM
 Problems: As before + end of the follow-up phase
 Items: None
 Intervention: As before
 Evaluation: Patient was coping all right, happy with her boyfriend, had a part-time job
 Follow up terminated

Researcher analysis and final evaluation:

Vicky was sensitive about being black, with very low self confidence. This could be because of her broken marriage or social relations with neighbours and colleagues; also due to feelings of guilt and shame over her behaviour in the past. None of her relatives were close, eg step father and mother, half sisters and brothers. She felt rejected by her husband, her family and people around her.

She needed acceptance, warm support, help and guidance; she needed to talk about her feelings to relieve the tension.

The hospital environment helped Vicky to build up her self confidence; therapeutic guidance and assistance helped her to resettle both socially and emotionally. However, the psychiatric symptoms needed psychotropic intervention.

Finally VC proved competent enough to carry on with her everyday life and was completely discharged from the researcher's follow-up.

Sadly, a few months later her relationship with her boyfriend deteriorated very badly and she committed suicide.

BAI₃₀ Assessment score of Vicky's condition

Item No	Section	Statement	BAI Score		
			Admission	Hosp discharge	End of follow-up
1	Communication and social skills	Non-verbal communication	2	4	4
2	"	Initiate conversation	1	4	5
7	"	Live peacefully with others	2	5	5
9	"	Accept success/failure	1	4	4
14	Insight	Realistic appraisal of current problems	3	3	5
15	"	Self confidence	2	4	5
16	"	Short/long term achievements	2	5	5
17	"	Sensible in dealing with problems	1	5	5
19	Self and family care	Personal hygiene	2	4	5
27	"	Deals with family problems	1	4	4
28	"	Seeking medical help	1	3	3
29	"	Work duties	3	5	5
30	"	Hobbies and activities	2	4	5

APPENDIX 24

BRIEF CASE STUDY

Personal Information (Source: hospital records and patient)

Patient's name: Angela Whitehead
Age: 23 years (1983)
Sex: Female
Marital Status: Engaged (lives with her fiancé)
Occupation: Student (at time of hospitalisation - gave up her course later)
Diagnosis: Anorexia nervosa, massive weight loss
Admission: Acute (1st hospitalisation)
Date of admission: March 1983
Date of discharge: June 1983
Period of follow-up: 8 months

Presenting picture (Source: hospital record and patient)

Massive weight loss, under 6 stone, height 152 cm. Worried about admission to a psychiatric ward. Does not eat regular meals, cuts down calorie intake. However, she enjoys preparing and eating meals and feels guilty if she has enjoyed a fattening meal and so compromises by not eating properly for the rest of the week.

Family and social history

Angela is the only daughter in the family and has been used to a lot of love and attention. She has only one brother who is 7 years older than she. Both her parents are slim, appreciate the value of this and speak ill of people who are obese. Her father had a heart attack the previous year. Her parents live in Great Yarmouth which meant Angela now had less contact with them.

Whilst in Sheffield Angela became emotionally involved with her fiancé, became engaged and they lived together. Her fiancé is also slim. He is a teacher of the French language.

Work: Used to be a student in the Department of Catering
Gave this course up during hospitalisation

Religion: Christian

Faith: Believes in God and goes to church regularly

Development of the problem

Angela's problem started after her father's heart attack in April 1982. At that time she was a student in the Department of Catering and had gained some weight as a result of practising and testing what she had cooked. She explained that she had joined the course specifically to become a teacher; however, in her final year a new regulation was introduced which prevented her from becoming a teacher at the end of this course of training. This upset her and she did not attend lectures regularly, and also drastically reduced her calorie intake. At the beginning of 1983 her condition deteriorated and she spent most of her time doing nothing at all, leaving the house in a terrible mess and spending her time lying in front of the fire.

Her parents were worried by her condition and requested medical help and as a result she was admitted to Ward 56 at the Northern General Hospital.

Hospital Intervention

A special behaviour programme for treating the anorexia was designed for her by the consultant. This consisted of:

First phase:

- a) confining the patient to bed apart from going to the toilet
- b) depriving the patient of most of her freedom for everyday activities such as washing, receiving visitors, watching TV
- c) providing special high protein, high calorie diet
- d) weighing her three times a week to measure any weight increase
- e) checking the weight increase was in accordance with a weight chart which indicated a reward for each stage reached. Rewards were in the form of gradual return of freedom for everyday activities and increased visiting hours

Second phase

- a) patient gradually allowed to get out of bed, first for 2 hours, then 4 hours until reached free mobility
- b) joining group therapy activities in the day hospital
- c) spending more time with her fiancé, going out for a meal and spending a whole weekend with him

Third phase

- a) encouraging outdoor activities and maintaining the weight gain
- b) discharge from in-patient care with attendance 3 times per week as a day patient, eating her meals at the hospital, being weighed and attending the group therapy sessions

Researcher Intervention

- a) Incorporated with hospital system, ie supervision of the behaviour programme, participation in group therapy and ward rounds, reporting, reviewing and participating in additional planning and modification.
- b) Individual therapy based on the psycho-analytical school, supportive therapy and insightful therapy.

Daily contact with the patient was provided in the first three weeks, later sessions became weekly according to the patient's needs.

Community follow-up was held in an interview room in the hospital.

- c) One session involved a psychologist.

Intervention Plan

- 1. Help the patient to understand, accept and acknowledge the behaviour programme
- 2. Encourage her to accept the target weight and work to obtain it
- 3. Support her during the conflict of gaining weight and losing control over her body (disclosed later in the intervention diary)
- 4. Encourage her to discuss her feelings towards her problem, her fiancé, her family, hospitalisation, academic achievements and therapeutic plan
- 5. Help her to overcome her decision regarding her future marriage plans and completion of her course
- 6. Plan for discharge, follow-up, day hospital services and range of activities obtainable and recommended

BAI₃₀ Assessment

BAI was scored below 4 on the following items:

9, 10, 11, 13, 14, 16, 17, 20, 21, 24, 25, 26, 27, 28, 29, 30

- 1. Unable to accept any changes in her future academic prospects. Felt jealous of her fiancé because he had achieved what she had failed to do.

No 9

- 2. Talked about many superficial topics without revealing her true feelings. Complained a lot about the hospital regulations and therapeutic plan without recognising her negative feelings. Did not see that she had any problem apart from irregular eating habits and did not see any point in being hospitalised in a psychiatric ward. She wanted discharge as soon as possible in order to prepare for her wedding.

Nos 10, 11, 13, 14, 16, 17

3. Massive weight loss, very skinny and bony. Very irregular eating habits, one meal a day, no balanced diet, lots of black coffee. Does not look after the house, causing a fire hazard. Does not spend money sensibly, but buys toys, magazines and newspapers.

Nos 20, 21, 24, 25, 26

4. Does not acknowledge or deal with her family problems. Does not ask for medical help when required. Dropped her course - failed to attend. Does not pursue any hobbies or activities.

Nos 27, 28, 29, 30

Intervention Diary

Intervention diary in this case dealt with selected sessions which were of significance both for patient progress and for development of the therapeutic plan. Much time was spent in informal chats with, and support of, the patient.

1st week:	4th week of March 1983
Interview:	With ward Staff Nurse Discussion focused on history taking, filling in hospital record
Problems identified:	Eating disorder, massive weight loss
Intervention:	Complete bed rest, implementation of the behaviour programme Support and comfort of the patient (1st time admitted to hospital) Observation, weight chart, informal talks
Evaluation and outcomes:	Patient responded to questions, accepted admission Expressed her worries about hospitalisation in a psychiatric ward
2nd session:	Following day of admission
1st interview:	1st contact between AW and NM
Problems:	As above and dissatisfied with therapeutic behaviour programme
Items:	9, 10, 14, 16, 17, 20, 21, 24, 25, 26, 28
Intervention:	Discuss the origin of her eating problem, points of dissatisfaction with the required modifications Promise to discuss these modifications with her consultant Explain the reason and philosophy for this plan Encourage her to accept the programme Ask her cooperation in the researcher's project
Evaluation:	Patient very pleasant, cheerful and talkative, agreed to try to cope with the therapeutic programme, to cooperate in the researcher's project and to fill in the questionnaire forms

3rd session:	1st week of April
2nd interview:	AW with NM and the consultant
Problems:	As before + childish behaviour, lack of real motivation for change, low tolerance
Items:	As above
Intervention:	Discuss the requested modification with the consultant Encourage the patient to explain her point of view in this respect
Evaluation:	Consultant agreed to add the suggested modifications eg able to receive telephone calls, more extended visiting hours, able to listen to the radio
4th session:	2nd week of April
3rd interview:	AW with NM
Problems:	As above + worried about being alone in hospital during Easter (many patients go on holiday) and about her end of term exams
Items:	As above
Intervention:	Reassure the patient by planning some ward activities for those patients remaining on the ward Discuss her worries about the end of term exams and find out what could be done about them
Evaluation:	Patient was pleased with the planned indoor activities Requested to be allowed to contact her course tutor Patient was pleased with her weight gain as it gave her freedom to wash her hair and bath herself
5th session:	3rd week of April
4th interview:	AW with NM
Problems:	AW is very worried about her weight gain, thought it was too much, that she was being fattened like a pig, and that she was losing control over her body shape (fat tummy)
Items:	14, 20, 21
Intervention:	Discuss the problem of weight gain, listen to her suggestions for modification Encourage her to discuss the logical changes with her consultant Encourage her to occupy herself with other interests and to be less concerned with her diet problem
7th session:	2nd week of May
6th interview:	AW with NM, nurse key worker, and consultant
Problems:	AW lost weight and was accused of taking laxatives to prevent weight gain Her room was searched for laxatives and she was put back on bed rest AW very upset, compared her therapeutic plan with that of other patients' (other consultants do not use this behavioural programme but patients are allowed their usual freedom)
Items:	As above
Intervention:	Discuss the problem in detail Support AW's point of view to be allowed time to accept her weight and to begin talking about her

	emotional problems Support the proposal for free movement and for her to begin attending group therapy Consultant agreed to the new plan and allowed the nursing staff to control the plan providing they could maintain AW's weight gain AW was very pleased with the new regulation
Evaluation	
8th session:	3rd week of May
7th interview:	AW with NM
Problems:	Very little weight gain Did not discuss her feelings or problems Does not actively participate in group therapy Exercises secretly Complains about the hospital food and does not eat all that is given to her; takes more than 2 hours to finish a meal
Items:	As above + 17
Intervention:	Discussion focused upon: <ul style="list-style-type: none"> - staff dissatisfaction with her behaviour - attending group therapy regularly - try to take less time in eating and eat the full amount given to her
Evaluation:	AW explained that her target is to maintain weight gain with full activity She denied having any psychological or family problems
9th session:	4th week of May
8th interview:	AW with NM
Problems:	Prepare for discharge Plan follow-up care
Items:	12, 13, 16, 17, 18, 20, 21, 27, 28, 29, 30
Intervention:	Consultant arranged for her to attend the group therapy twice a week, to receive her meals and to be weighed Discussion focused on her future plans (preparation for the wedding)
Evaluation:	AW maintained her target weight (7 stone) for 2 successive weeks Promised to increase her weight to 7.6 stone in the near future. Angela was looking forward to getting married in August

Community Follow up

10th session:	2nd week of June
Problems:	Very upset because consultant has advised her fiancé to postpone the marriage arrangements for 6-8 months. Consultant's explanation is that Angela is suffering a great conflict between becoming a mature, responsible woman and remaining like a child, enjoying being the centre of attention and having no responsibilities to carry.
Items:	13, 16, 17, 27
Intervention:	Discussion focused on: Consultant's interpretation and analysis of Angela's condition; her agreement or otherwise of that view; her feelings towards her fiancé; her duties as a wife, their sexual relationship and satisfaction.
Evaluation:	Angela agreed with consultant's interpretation but would not agree to postpone the marriage. She thought that marriage would help her to mature, and in fact she is already living with her fiancé. She did not like the negative social consequences of postponing the wedding nor the financial loss of doing so.
11th session:	1st week of July
10th interview:	AW with NM on the telephone
Problems:	AW only attended day hospital for a week Still has eating problem, wary about any food she eats and struggles to eat at every meal Busy preparing for her wedding and her mother is visiting her also to make wedding plans
Items:	20, 21, 27
Intervention:	Discuss her eating problem with her. Explain that there is still enough time to postpone the wedding Encourage her to be weighed in the hospital
Evaluation:	Angela refused to postpone her marriage, explained that she is all right and that her mother is supervising her diet
12th session:	3rd week of July
11th session:	AW with NM
Problems:	As above and weight loss, feeling sick, worried and anxious about the future Refused to postpone her marriage plans Her fiancé is worried about her health and eating problem but cannot persuade her to postpone the wedding
Items:	As above
Intervention:	Encourage her to see the consultant, explain the problems that may arise from getting married while still unfit Advise her to postpone the marriage Encourage to speak about her feelings
Evaluation:	Angela decided to go ahead with her wedding plans Promised to see consultant - but she did not do so.

September/October 1983

Angela did not get in touch with her consultant or the researcher after returning from her honeymoon. The staff of the day hospital and the researcher phoned her several times with no reply. The researcher wrote to her asking her to get in touch. Again no answer was received. The researcher then phoned her in the evening and her husband answered. He said that Angela is struggling with her food and is worried about everything she eats and that she has lost weight. He said that she was not at home at the moment as she had gone out for a meal with some friends. He promised to make her get in touch.

13th session: 2nd week of October (the following evening)
12th interview: AW with NM on the telephone
Problems: As above + gave up her catering course and begun a new clerical job
Items: 12, 13, 14, 16, 17, 20, 21, 28
Intervention: Arrange to see her as soon as possible
Encourage her to maintain her weight
Encourage her to see her consultant
Evaluation: Angela said that she is busy with her work, so cannot afford to see NM between 9am and 5 pm, and the same problem applies to seeing Dr JS
Accepted an invitation to come to the researcher's house for an evening meal
Promised to maintain her present weight of 6 stone

14th session: 3rd week of October
13th interview: AW with NM at her house
Problems: Massive weight loss. Takes long time to eat, adds a lot of hot spice to her food, avoids starchy, fattening food, concentrates on salads. Drinks strong black coffee with no sugar.
Items: As above + 27
Intervention: Discussion focused on:
1. Her eating habits and what she can do about them
2. Massive weight loss, threat to her health and life
3. Work duties and her inability to cope
4. Her marital relation and sexual dissatisfaction
5. Her illness and what could be done about it
Draw up with her a plan to control these problems
Evaluation: This session was the most useful one
Angela was open and spontaneous, spoke about her eating problem, about being fed up with being unhealthy, wants to be normal but terrified of becoming fat because she loves food and enjoys eating. Also wants to have a small stomach because it protrudes after eating anything which is why she does not have breakfast or lunch. The evening meal is her only meal and it usually consists of salad and boiled vegetables with no bread or butter. She prepares another meal especially for her husband. She loves cooking and likes to watch other people eating.
She dislikes obese people and her family are the same - they used to make jokes about their fat friends or neighbours. Her husband is thin and she

is pleased about that.

She promised to follow the diet plan and to meet the following week in town, during her lunch break

15th session:	4th week of October
14th interview:	AW with NM (in a cafeteria in town)
Problems:	Difficulty in following the plan Struggling with food Managed to put on one pound during the week Is worried about how fast she can gain weight and her stomach gets bigger
Items:	20, 21
Intervention:	Explain to her the reason for her big stomach (feeble muscle tone, symptom of starvation and lack of exercise) Advise her to do some exercises to increase muscle tone Encourage her to follow the plan, to accept the weight gain and to put on another pound in the following week Arrange for her to see the consultant in the outpatient department
Evaluation:	AW was very worried about meeting the consultant but agreed to see her in the outpatient department. Promised to put on some more weight during the week
16th session:	1st week of November
15th interview:	AW with consultant and NM
Problems:	As above
Items:	As above
Intervention:	Discussion focused on her ways of coping, what help could be offered by consultant and NM Encourage her to accept hospitalisation Review the diet plan
Evaluation:	Angela refused hospitalisation, promised to follow the diet plan and put on weight Another appointment made with Dr JS in two weeks' time.

November/December 1983

Angela did not improve much during the following weeks, kept on putting on weight and then losing it the following week, never followed the diet plan. Her relationship with her husband began to deteriorate, he stopped talking to her or eating what she had cooked for him. She left her job and went to college to do a secretarial and office practice course. However, at college she used to fall asleep during lectures and lacked the ability to concentrate. Over Christmas, at her parents' house, everybody commented on how thin she was.

Eventually Angela agreed to be admitted to hospital in February 1984, after her condition had deteriorated markedly and her life was in danger. She weighed 5.4 stone, was very thin and bony, pressure sores were all over her body, her skin was dry and dehydrated and she had disturbed electrolyte balance. She admitted to having pains all over her body and that her marriage was threatened.

17th session:	2nd week of February 1984
16th interview:	AW with NM (in the hospital)
Problems:	All the above + admitted behaving negatively to persuade her husband to look after her and pay more attention. Her plan did not work - he kept avoiding her
Items:	As above + 27, 28
Intervention:	Advise her to: <ul style="list-style-type: none"> - Follow the dietary programme drawn up for her - Behave in a mature, grown-up way and to stop moaning about everything - Try to get the support of the consultant by following her instructions - Promise to talk to her husband and discuss the problem with him and ask him to come and visit her
Evaluation:	<p>Angela was very sad and depressed, worried about her marriage. She promised to look after herself and stop behaving in an immature way.</p> <p>On the telephone her husband was very upset about Angela's behaviour, could not understand the meaning of her illness and asked for professional help so that he could learn more about anorexia nervosa and how to deal with it.</p> <p>Consultant met him alone at first and then with Angela.</p> <p>The session revealed a lot of conflict between the couple. Further sessions were recommended.</p> <p>The husband was given a book to read about anorexia nervosa.</p>
18th session:	2nd week of March
17th interview:	AW, with husband and NM and a staff nurse
Problems:	<p>Angela feels jealous of her husband because he is successful and she is not</p> <p>She blames him for not giving her enough attention and not understanding her needs</p>
Items:	As above
Intervention:	<p>Encourage the couple to be open about their feelings and not to get angry</p> <p>Discuss openly their problems, even the sensitive embarrassing ones</p> <p>Ask them to evaluate their relationship and detect its positive and negative aspects</p>
Evaluation:	<p>Angela was more open about her feelings than was her husband</p> <p>He accepted all her accusations and promised to help her in the future as he understood better her problems, especially after reading the book about the illness</p>

Another two marital therapy sessions were carried out by the researcher and the nurse key worker. The sessions had to stop as the husband was very reserved about his feelings and played a passive role. Angela was much better regarding her eating problem, regained a reasonable weight and became more insightful about her behaviour. However, she continued being fragile and needed constant follow up.

Termination of the researcher follow-up had to take place. The consultant decided to refer Angela to a CPN after her discharge from hospital.

Researcher analysis and interpretation

It was difficult to locate the main problem with Angela. Her consultant recognised her as an immature person who refuses to grow up and, therefore, does not eat. Her aim in getting married was far from starting a new family; what she wanted was a wedding dress and a party and to go abroad for a holiday. When this was over she started her immature behaviour again.

This explanation was certainly true in Angela's case but the diet programme was reinforcing treatment of Angela as a child who should be forced to eat and to do things that adults wanted her to do.

Like most anorexics, Angela was very good at talking and covering up, to convince the staff of her point of view. She succeeded several times. This resulted in dividing the therapeutic team into two sides: the consultant on one side, nursing staff and the researcher on the other side. The two sides' points of view were implemented in the therapeutic approach with Angela and both proved to be successful in the short term but neither were successful in the long term. Angela was not prepared to change because to her change means losing control, losing attention and the child's freedom; therefore neither of the therapeutic approaches was successful with her.

No improvement was noted when she went ahead with her plan: marriage, loss of weight, getting a new job, seeking her husband's attention. This plan failed and she found herself in pain, rejected and her marriage threatened. Only then did she begin to realise the importance of change and agreed to professional help.

The BAI 30 scores on assessment of Angela's condition

Item No	Section	Statement	BAI Score		
			Admis-sion	Hosp dis-charge	End of follow-up
9	Communication and social skills	Accept success/failure	1	1	3
10	Insight	Discuss personal feelings	1	4	5
11	"	Awareness of negative feelings	3	4	5
13	"	Described incidents that caused security/insecurity	3	3	3
14	"	Appraisal of current problems	1	4	5
16	"	Short/long term achievement	1	2	2
17	"	Dealing with problems	1	3	3
20	Self and family care	Food intake and physical health	1	3	2
21	"	Eating habits	1	2	1
24	"	Avoidance of household dangers	2	5	5
25	"	Management of finance	2	4	4
26	"	Responsibility for everyday needs	1	4	3
27	"	Family problems			
28	"	Seeks medical help	1	2	1
29	"	Work duties	2	2	4
30	"	Hobbies and activities	1	2	5

APPENDIX 25

BRIEF CASE STUDY

Personal Information (Source: hospital record)

Patient's name: Saddek Abed-El-Hamid
Age: 25 (1984)
Marital status: Single
Occupation: Driver for a large company in Cairo
Diagnosis: Grand mal epileptic fits following brain surgery, anxiety, depression, aggressive behaviour
Admission: Acute (1st admission)
Date of admission: July 1984
Date of discharge: November 1984
Period of follow up: 3 months

Presenting picture (Source: hospital record)

Grand mal epileptic fits, verbal and physical aggression towards colleagues at work, very anxious about his condition, feels depressed and useless.

Tremors in the hands and weakness of the arm muscles.

Brain surgery to remove a benign tumour the previous year: the above complaints were not present before brain surgery.

Family and social history (Source: patient)

Saddek was born and had lived in Cairo all his life. His father is a religious person of Muslim faith who was always critical of Saddek's unacceptable behaviour. His father suffers from heart disease which allows him only to work part-time, ie does not earn much money.

Saddek's mother died a long time ago and he has a step mother and one younger half brother and two elder brothers. The two elder brothers are married and separated from the family but Saddek still lives in the family house.

Saddek is a very sociable person who has many friends and acquaintances with whom he spends most of his free time.

Work: Used to work as a car mechanic, then got a well-paid job as a minibus driver with one of the large companies in Cairo

Religion: Islam

Beliefs: Believes in God but does not observe the Muslim rules

Development of the problem

Saddek is in love with a girl whose family will not allow him to become engaged to her until he can get a flat. Saddek does not have enough money to afford to rent or buy a flat in Cairo. None of his brothers or father can help him financially; besides which they do not approve of him wanting to marry this girl as her family do not have a very good moral reputation.

Saddek has been earning a good income but he also used to spend it all unwisely on socialising and smoking hashish. This behaviour also was very much disapproved of by his religious father. Saddek became very depressed over his inability to pursue what he wanted as well as over the physical disability recently experienced.

BAI₃₀ Assessment

Scores were below 4 on the following items:

Nos 6, 7, 9, 11, 12, 13, 15, 16, 17, 25, 27, 28, 29, 30

These items were represented by the following features:

1. Preoccupied with his problems, not actively listening to others' discussions or conversations
Became aggressive, both verbally and physically, towards his colleagues at work and to the hospital staff
Unable to accept failure in achieving his plans

6, 7, 9

2. Gets angry very easily and reacts impulsively, without thinking
Is not aware of the real cause of his aggression
Uses a lot of projection
Thinks of himself as useless
Does not have any logical plans for the future
Cannot work out a sensible plan for solving his problems

11, 12, 13, 15, 16, 17

3. Spends his money excessively on socialising
Many family problems within his family as they disapprove of his behaviour
Has failed to get approval from the parents of his girlfriend
Did not complete any educational level, has only limited manual skills which are now threatened by his physical disability

24, 27, 29

Plan of Work

1. Examine and work on both the physical and emotional disabilities
2. Encourage him to stop his antisocial behaviour
3. Help him to become aware of the nature of his negative feelings and unacceptable reactions
4. Help him to prepare a plan to deal with his problems, on a scale of priorities
5. Teach him socially-acceptable coping mechanisms
6. Plan for discharge and follow-up phase

Hospital Intervention

Mainly chemical and medical to control the epileptic seizures, group therapy for coping with the consumption of hashish problem

Researcher Intervention (delivered at the request of the hospital and patient)

- a) Join the ward rounds, discussion and review of care plan with the medical staff and participation in the weekly therapy sessions held by the consultant
- b) Individual therapy, joined session with the consultant on one occasion

Insight and supportive psychotherapy approaches were used. Sessions were on a weekly basis during hospitalisation and every alternate week during the community follow-up. Follow-up sessions were held at the patient's house.

Intervention Diary

1st session:	2 months after admission, 2nd week in September 1984
1st interview:	SE with NM
Problems identified:	Sad, depressed, anxious, worried about his future physical condition Dissatisfied with the hospital services, argued with staff, broke a glass window the previous week and hurt his hand Has tremors in both hands Financial and emotional problems Family and social problem
Items:	6, 7, 9, 11, 12, 13, 15, 16, 17, 25, 27, 29
Intervention:	Accept patient's request for interview and involvement in his therapy Encourage patient and listen to him talking about his problems Accept his dissatisfaction with the hospital services Inform him about the research work and ask for his cooperation
Evaluation:	Patient was pleased to find a listening ear and to receive acceptance An outline plan of care was drawn up He agreed to participate in the research project
2nd session:	3rd week of September
2nd interview:	SE with consultant and NM
Problems:	Patient was threatened with being put in a closed ward after attacking one of the medical staff Not allowed to go outside the hospital Patient dissatisfied with the hospital service Worried about his physical condition
Items:	6, 7, 11, 12, 13
Intervention:	Discussion focussed on: <ul style="list-style-type: none">a) Making a contract between consultant/NM and SE about the acceptable behaviour he should pursueb) Helping the patient to express his feelings of dissatisfaction with the hospital service in the presence of consultantc) Encourage the patient to talk about his feelings towards the medical and nursing staff and his expectations from them

Evaluation: Patient was very open about his feelings
 Consultant communicated his refusal to accept the patient's violent behaviour
 Agreement was reached regarding the contract items:
 SE promised to stop behaving aggressively
 SE asked that a certain member of medical staff should not be involved in his therapy
 NM supported SE in his request to be kept in the open ward
 Consultant accepted the patient's requests

3rd session: 4th week of September
 3rd interview: SE with NM
 Problems: Patient admitted he consumed hashish weekly
 Tremors in his hands and general weakness
 Irregular meals, disliked hospital food
 Wants to see his girlfriend
 Worried about his father's health
 Wants to see the surgeon who carried out his brain surgery
 Items: 17, 25, 27
 Intervention: Arrange for the patient to have an appointment to meet his surgeon in 2 weeks' time to discuss his physical disabilities with him
 Encourage the patient to eat more regular meals and to ask the hospital to provide him with food he likes
 Increase the patient's awareness of the bad effects of the consumption of hashish
 Encourage him to stop smoking cigarettes and hashish
 Evaluation: Patient promised to stop taking hashish and to decrease the number of cigarettes smoked
 Less anxious about his physical condition
 Pleased to have an appointment with his surgeon
 Still worried about his father's health and about his girlfriend

4th session: 1st week of October
 4th interview: SE, his eldest brother with NM
 Problems: Patient's financial and emotional problems
 His brother suggests that SE get married to one of their neighbours whose family are financially comfortable which would help SE a lot
 SE cannot make the decision
 Items: 24, 27
 Intervention: Discussion focused on SE's need to marry and his financial problems
 Support was given to SE to take time to think about his brother's suggestion
 Evaluation: SE suffered great conflict
 He wants to please his father and brother and so go ahead with an arranged marriage but at the same time he is still madly in love with his girlfriend
 His father's health condition had improved

5th session: 2nd week of October
 5th interview: SE, NM with the surgeon
 Problems: Physical complaints discussed
 Items: 8, 15
 Intervention: New medication to control the tremors was prescribed
 Great support and encouragement were given by the surgeon to SE
 Evaluation: Patient feels much happier about his condition

6th session: 3rd week of October
 6th interview: SE with NM
 Problems: The arranged marriage procedure failed because of the stigma of hospitalisation in a mental hospital
 Patient depressed and feeling useless and worthless
 Decided to see his girlfriend whatever trouble it might cause
 Started smoking hashish again
 Items: 11, 12, 15, 17, 27
 Intervention: Encourage the patient to express his painful feelings
 Discuss with him the community attitude towards mental hospital
 Encourage him to take positive action towards rehabilitation and discharge
 Try to persuade him not to visit his girlfriend to avoid causing problems with her family
 Encourage him to attend consultant's group therapy for drug addiction
 Evaluation: Patient did not accept the advice not to see his girlfriend but succeeded in meeting her secretly
 Accepted that his illness is mainly physical and not mental ie less social stigma
 Began to attend regularly at consultant's group therapy

7th session: 4th week of October
 7th interview: SE with NM
 Problems: According to legal regulations, the hospital report will include a recommendation to his place of work that he should stop driving and work fewer hours
 This was very upsetting for SE as it would mean earning much less money
 Wanted to discharge himself and start working
 Items: 16, 25, 29
 Intervention: Patient was instructed to take a gradual discharge by spending 2 days and 2 nights at home to test his ability to manage
 Explain to the patient that driving is considered very dangerous for him and for anyone riding with him
 According to the law he should change his driving job for another job
 Evaluation: Patient was very upset by this new problem
 It was difficult for him to accept and asked to see the director of the hospital to seek the exact information that would be included in the report
 Patient was reassured when the hospital director explained the situation to him and promised to write a good report which would guarantee all his financial rights
 Discharge from hospital was agreed by the hospital director on a gradual basis followed by two weeks' sick leave

Community follow-up

8th session:	2nd week of November 1st home visit
8th interview:	SE, step-mother with NM at his family flat
Problems:	SE does not take his medication regularly Spends a lot of time outside, not returning home until 2 am Unable to sleep at night and does not get up until midday Started to smoke hashish again Does not do anything all day Verbal aggression towards his younger brother Unable to work out a plan to solve his financial and emotional problems
Items:	7, 9, 14, 16, 17, 25, 27, 29
Intervention:	Listen to both sides - the patient and his step-mother Explain to the step-mother the nature of SE's problem and difficulties Ask her to be more supportive than critical of his behaviour Accept her dissatisfaction with his verbal aggression Encourage the patient to talk about his feelings towards his family and how he perceives their criticism (this was done on an individual basis) Outline a plan for him to start work as a car mechanic and to save money so that he can marry his girlfriend Advise him to take his medication regularly, take regular meals and stop smoking hashish
Evaluation:	Step-mother pleased to find some support for her views and to receive a promise from SE to stop verbal aggression Patient promised: to take his medication regularly to start work as a mechanic in a private garage to stop smoking hashish to save some money
9th session:	3rd week of November
9th interview:	SE, his father, with NM at his family flat
Problems:	SE does not take his medication, cannot sleep at night, has had one epileptic fit Needed emergency treatment at hospital the previous night for analysis and sedative SE complained of his weak arm muscles and his inability to fix car parts which need physical strength Same emotional and financial problems
Items:	25, 27, 29
Intervention:	Listen to his father and respect his feelings Explain ways of support he can offer SE, by being more understanding and less critical Encourage SE to come to El Niel Hospital for medical check up as soon as possible and for readmission if necessary
Evaluation:	The father was rather rigid and did not believe SE could change to better behaviour SE was worried about his physical health, not happy about having to go to El Niel Hospital again but promised to go in 2 days' time and to take his medication

10th session: 4th week of November (readmission)
 10th interview: SE with NM in hospital
 Problems: Same as before
 Items: As before
 Intervention: Advise the patient to take medication regularly and remind him of his promise to do so
 Evaluation: Patient is more aware of the negative consequences of not taking his medication and his disorganised way of living
 He is more determined to cope with his problems
 Hospitalised for one week then will be discharged again

11th session: 2nd week of December
 11th interview: SE with NM at his family flat
 Problems: Getting used to his new job as a mechanic
 Coping with his emotional problems
 Items: 27, 29
 Intervention: Support the patient in his decisions to start work
 Encourage him to:
 continue saving money
 try and gain approval of his family to marry his girlfriend
 try and discuss possibility of proposing again with his girlfriend's family
 Evaluation: Patient was more confident, had saved about £500, was more determined to continue saving and to find a solution for his emotional problems
 Patient stopped smoking hashish and started to pray regularly
 Patient returned to work.
 His father pleased at the change

12th session: 4th week of December
 12th interview: SE with NM at his family flat
 Problems: His girlfriend's parents refused his second proposal
 Items: 27
 Intervention: Discuss his feelings, support and encourage him to cope
 Evaluation: SE not happy about the rejection of his second proposal
 Decided to wait until saved enough money, then would get married and live in any sort of accommodation (eg a rented room in a shared house)
 He was still praying regularly and settled at work

13th session: 2nd week of January 1985
 13th interview: SE, his father and elder brother with NM
 Problems: As before
 Items: As above
 Intervention: Discussion focused on:
 Patient's family attitude towards his girlfriend
 Means of financial help
 Their evaluation of his current behaviour
 Evaluation: Patient's father and brother were very supportive to SE and pleased with the change in his behaviour
 They were still reserved about his girlfriend, could not approve of her, but agreed to give him the opportunity for free decision
 Patient still determined to marry his girlfriend

14th session: 4th week of January
14th interview: SE with NM at his family flat
Problems: As before
Items: As before
Intervention: Support and encouragement
Evaluation: SE's brother found him another part-time job, ie better income
His emotional problems not solved yet
Physical and medical condition more stable
Termination of follow-up

Researcher impression and analysis

Saddek was put under pressures which he could not resolve. The brain surgery he had undergone two years previously resulted in the development of epileptic fits which prevented him from pursuing his job as a driver. Although at first the researcher did not consider involving Saddek in her study, yet the patient was aware of his needs and problems and requested her help. He needed to talk about his problems, learn more about his disabilities and healthy methods of adjustment. He used to behave aggressively both verbally and physically towards anybody, however he did not like this behaviour and wanted to learn more acceptable ways of expressing anger.

He had great emotional and financial problems, which were linked together, producing intense pressure upon him. His family problems, also, with his father and the lack of support which he needed had pushed him to find acceptance from his group of peer friends whose social entertainment was mainly smoking hashish.

Although his father and his brothers were genuinely concerned about him they missed the correct approach to help and put him in many conflicting situations eg not to marry his beloved, to marry another whom they had chosen, to stop smoking hashish (ie stop mixing with his friends).

Saddek wanted to change but did not know how. Great progress was achieved through individual/group therapy sessions and some education of the family. The success with this patient was mainly achieved through his determination and the genuine concern/support provided by his family.

BAI₃₀ Assessment score of Saddek's condition

Item	Subject	Statement	BAI Score		
			Admissions	Hospital	End of follow-up
6	Communication and social skills	Attentive listening	3	4	5
7	"	Live peacefully with others	2	2	4
9	"	Accept success/failure	3	3	4
11	Insight	Awareness of negative feelings	3	5	5
12	"	Identify cause of negative feelings	2	5	5
13	"	Describes real incidents that cause security/insecurity	3	4	4
15	"	Self confidence	3	4	4
16	"	Short/long term achievement	2	3	4
17	"	Dealing with problems	2	3	4
25	Self and family care	Manages finance	2	4	4
27	"	Family problems	2	3	4
29	"	Work duties	3	4	5

APPENDIX 26

BRIEF CASE HISTORY

Personal information (Source: hospital records)

Patient's name: Nadia El-Gamale
Age: 28 years (1984)
Sex: Female
Marital Status: Divorced, no children
Occupation: Unemployed
Diagnosis: Personality Disorder
Admission: Acute (2nd admission)
Date of admission: September 1984
Date of discharge: October 1984
Period of follow up: 3 months

Presenting Picture (Source: Hospital record and patient)

Feelings of persecution, big problems with the family, problems with colleagues at work, resigned from work, feeling unhappy, weepy.

Family and social history (Source: patient and personal observation)

Nadia is living in her family house; she came from a very rich family who are running large businesses in different parts of Egypt and other Arab countries. She has six sisters, she is the fourth daughter. All her sisters are married or engaged except herself and one other sister. All her sisters finished with a high level of education (university, have beautiful homes, well-established houses and families). Nadia could not continue with preparatory school, could speak a little French.

The other unmarried sister is younger than her, more beautiful than her, a university graduate and was delegated by her father to look after the family financial affairs during his absence. The father and mother are separated but not divorced. The mother is living in the house but the father is not. The house is filled with grandsons, daughters, 2 domestics, 1 cook and a female tailor.

Work: Used to work as a receptionist in a hotel for a few pounds per month
Religion: Islam
Beliefs: Believes in God, but does not observe any of the Islamic rules.

Development of the problem (Source: patients, hospital doctor and family)

This is Nadia's second admission, the first one was during the previous year. Her family had admitted her because of her aggressive behaviour, both verbal and physical, and her repeated threats to throw herself from the 5th floor balcony. On this second occasion Nadia escaped from the house and admitted herself voluntarily to the hospital. According to Nadia she felt very persecuted by her family and became very anxious in case they had her admitted to a State Mental Hospital. She also had problems with her colleagues at work and she resigned to avoid any further hassle.

According to the family, Nadia is an abnormal person, not bright like her sisters. She had failed to succeed both in her studies and in her marriage. She was jealous of everybody and thought everyone was teasing her. She got very aggressive when her younger sister became engaged and used very bad words in the presence of her sister's fiancé and his family. She accused everybody of wanting to get rid of her by admitting her to a mental hospital in order to have her share of the money. On the day following this incident she disappeared and her family discovered that she had given all her new expensive clothes to one of their ex-domestics and they did not know where she was until the hospital informed them.

BAI₃₀ Assessment

BAI₃₀ scores were below 4 in the following items:

Nos 7, 9, 10, 11, 12, 13, 14, 15, 16, 17, 19, 26, 27, 29, 30

These items were represented by the following features:

1. Verbal and physical aggression towards the family.
Feelings of persecution and rejection

Items: 7, 9
2. Hid many of the incidents and discussed only what would be in her favour.
Became angry very quickly and behaved impulsively
Cannot identify the real reasons for her negative feelings
Gives only partial description of the real incidents which make her insecure
Does not know how to analyse her problems
Lack of self-confidence - sees herself as a divorced, unsuccessful and less beautiful woman
Cannot decide about the future
Cannot face a resolution to her problems

Items: 10, 11, 12, 13, 14, 15, 16, 17
3. Gave away her clothes and left only one unsuitable dress which she wore all the time
Does not look after her financial affairs - leaves it to her younger sister
Complicated multiple family problem
Problems with colleagues at work followed by her resignation
No friends or hobbies - spends all her day at home

Items: 19, 26, 27, 29, 30

Plan of Work

1. Convey respect, understanding, love and acceptance
2. Gain the patient's trust
3. Encourage her to talk about her problems, feelings, and wishes
4. Encourage the patient to improve her self esteem and join her in social and domestic activities
5. Get in touch with the family and work as a liaison between both sides
6. Gain the trust of the family, give them support and understanding
7. Involve the patient in decision-making about plan of intervention and future management
8. Plan for discharge and follow up.

Hospital Intervention

Mainly chemical and little psychotherapy in the form of discussion and disapproval of her unacceptable behaviour.

Researcher Intervention

- a) Join the ward rounds, discuss her condition and review the care plan
- b) Individual therapy, joint sessions with consultant
Insight, supportive and reality psychotherapy approaches were used.

Sessions were on a weekly basis during hospitalisation, and every 3 weeks during community follow-up; sessions were held at the patient's place of work.

Intervention Diary

1st session:	Admission 1st week of September 1984
Hosp Interview:	Hospital Resident Dr with patient
Problems:	Patient, sad, weepy, escaped from the family house, feelings of persecution and rejection.
Intervention:	Accepted her request for admission Admission to closed ward Minor tranquilizers to calm her down and reassurance given Family informed
Evaluation and outcomes:	Patient less apprehensive but refused to see anybody from her family
2nd session:	2nd week of September First contact with NM
1st interview:	NE with consultant and NM
Problems:	Sad, anxious, feelings of persecution and rejection, unable to cope with her family problems. Feelings of inadequacy, failure, less attractive than her sisters, does not want to return home at all but wants to stay in the hospital. Does not have clothes with her except for one dress which she wears all the time.
Items:	7, 9, 10, 11, 12, 13, 14, 15, 16, 17, 19, 26, 27, 29, 30
Intervention:	Encourage her to talk about her problems in detail Give her a safe environment to express her feelings and points of view Support, acceptance and understanding of her feelings Ask her co-operation in the research, fill in the questionnaire forms with her

Evaluation: Patient welcomed co-operation, discussed some of her problems
Was reluctant to be open about her feelings

3rd session: 3rd week of September
2nd interview: NE with consultant and NM
Problems: As before
Items: 10, 11, 12, 13, 15, 19, 27, 30
Intervention: Discussion focused on:
Encourage the patient to be more open about her feelings and speak about the unpleasant incidences she has been facing
Encourage her to pay some attention to her appearance
Encourage her to join in the hospital activities eg craft work and outings

Evaluation: Patient was more open about her feelings, spoke about her childhood and feelings of rejection since then, the family problems between her parents, and her unsuccessful marital life (was married against her will to an old man)
Accepted she should do some work, phoned her sister (the one she feels nearest to) and asked for some clothes. Joined the hospital outing (boating trip on the Nile)

4th session: 4th week of September
3rd interview: NE with consultant and NM
Problems: As before + refused to meet the tailoress when she came to see her and became aggressive towards her
Items: 7, 9, 10, 11, 12, 14, 27
Intervention: Discussion focused on:
Encourage the patient to give explanations for her behaviour
Encourage the patient to learn new modes of acceptable behaviour and expression of emotion
Help the patient to plan for the future and encourage her to accept a visit by NM to her family

Evaluation: Patient explained that the tailoress is evil, and had been encouraging her family to act against her and to take sides. NE agreed to act in a less aggressive way and to try to control her emotions
NE was unable to decide on a working plan
Agreed NM should pay a visit to her family but was very apprehensive about what her family might say to NM

5th session: 4th week of September
4th interview: NM with the patient's family at their house
Problems: Family (mother, two sisters, the husband of one of the sisters, a granddaughter [15 years old]) and the tailoress were very angry about NE's behaviour, threatening to leave her in a mental hospital if she would not alter her behaviour. They revealed all the problems she had initiated with the neighbours, relatives, domestics, children and colleagues at work. They explained that she misinterpreted any word said to her and perceived it as an insult; accordingly she behaved in a very aggressive verbal, sometimes physical, manner with the domestics and her neice.

Items: As before
Intervention: Accept the family's complaint
Discuss with them the different chances for gaining their support and help

Evaluation:	Ask them to show some love and affection Explain the pathological dynamics of NE's behaviour Encourage them to visit her in the hospital Discuss with them the plan for her discharge and return home A great deal of anger was expressed by everyone in the family Support was very hard to gain No-one agreed to visit her Expressed great apprehension about her return home Agreed that NE should come first as a visitor with NM to discuss with them the problem and try to find a solution
6th session:	1st week of October
5th interview:	NE with NM
Problems:	As before + apprehension about her visit to her family
Items:	As before
Intervention:	Reassure the patient that talking with her family had not changed my approach to respect and accept her Discuss with her problems revealed by her family and ask for explanations Encourage the patient to see her family's point of view and to promise to stop her unacceptable behaviour Discuss with her the plan of discharge and the kind of support she needs from her family
Evaluation:	Patient is still apprehensive about the visit to her family Suggested she should live in her flat with a domestic to look after her (NE owns a flat) or should live with her elder married sister whom she likes most. Patient happy to receive support and help in this phase.
7th session:	1st week of October
6th interview:	NE, her mother, younger sister with NM at the family house
Problems:	As before
Items:	As before
Intervention:	Discussion focused on helping the mother and sister to understand the pathogenesis of NE's behaviour through childhood, asking her mother about any incidents at NE's birth Accept mother's disapproval of NE's unacceptable behaviour Give the mother a chance to talk about her feelings Encourage the mother and sister to express their positive feelings towards NE Ask NE to apologise for her past unacceptable behaviour Suggest to the mother that she allows NE to live in her flat with a domestic to look after her
Evaluation:	NE was afraid and very apprehensive, kept silent most of the time, accepted her mother's complaints. Promised to stop this behaviour Mother at first still angry and avoided looking in NE's direction most of the time and refused to shake hands or kiss her The mother revealed that she had a difficult birth with NE who had nearly died because of lack of oxygen and massive bleeding. NM explained to the mother that such difficulties could have affected NE's rate of growth and development. The mother started to be more understanding and became interested in recalling all the different incidences that could have influenced NE's physical and psychological growth. The mother accepted that NE needs love and attention, accepted that NE's awkward behaviour was a call for attention and

finally agreed to have NE back at home under the condition that she would behave appropriately.
The suggestion that NE could stay in her flat was rejected.

8th session: 2nd week of October
7th interview: NE with consultant and NM
Problems: Going home, no work, boredom
Apprehensive about how the rest of her family members will receive her back
Items: 6, 7, 9, 14, 15, 16, 26, 27, 29, 30
Intervention: Encourage her:
to join some adult education courses
to learn needle work
to get in touch with the friends she trusts and visit them
to gain her mother's love and acceptance so she will not feel rejected any more
to pay some attention to her appearance so she can improve her self confidence
Evaluation: Patient accepted all the above suggestions
Discharge from hospital

Community Follow-up

9th session: 3rd week of October
8th interview: NE and her younger sister with NM at the family house
Problems: Big problem between NE and her younger sister and brother-in-law
She accused her sister of stealing her money and accused her brother-in-law of trying to get rid of her by trying to put her in a mental hospital
The family also were very unhappy about NE's behaviour and accused the hospital and NM of encouraging NE's misbehaviour
Items: 14, 17, 26, 27
Intervention: Discuss the problem with NE
Try to calm down the younger sister
Try to explain to NE the undesirable effect of her behaviour
Put forward some suggestion for solving this problem
Evaluation: The younger sister was very angry and could not accept any rationale for NE's behaviour. Decided not to talk to NE again and not to look after her financial affairs.
NE revealed that she receives about 200 Egyptian pounds every month from her father as spending money. After her discharge she found there was no money left for her. Her younger sister had explained that the money had been spent to cover the hospital charges. NE accepted this explanation but was not fully convinced.
NE agreed to NM's suggestion to keep her money in a bank

10th session: 4th week of October
9th interview: NM with NE at her work
Problems: Worried about starting a new job (receptionist in a small hotel)
Stigma of mental illness
No friends
Not talking to her younger sister or brother-in-law
Items: 15, 27, 29, 30

Intervention: Encourage NE to cope with her new job and to start making friends with her colleagues
Accept her decision to avoid talking to her younger sister and brother-in-law
Encourage her to visit some of her old friends and to visit her elder sister whom she loves
Advise her to keep the working hours to the usual rate and avoid having extra hours (ie to work from 10am to 4pm, not 10am to 9pm which she used to work, so as not to upset her mother)

Evaluation: Her relationship with her mother was very good and continued to improve
Her father returned to live with them in the family house and that pleased her very much as her brother-in-law stopped threatening to put her in a mental hospital
Her new job as a receptionist in a small hotel was very useful to her, she met new people, worked less hours, had fewer duties, became more confident of her abilities.
Began to pay more attention to her appearance
NM promised would not tell anyone at NE's work about her illness

11th session: 3rd week of November
10th interview: NM with NE at her work place
Problems: None
Items: None
Intervention: Support and encouragement was given
Ensure she is behaving appropriately and that no intervention is needed

Evaluation: NE is happier, more confident, more outgoing, visited her sister and developed new friendship with a female colleague

12th session: 2nd week of December
11th interview: NM with NE at her work place
Problems: Not feeling very happy because of the following:
a) the brother of her boss (an old man) had proposed marriage to her
b) Her cousin spoke to her in a very rude manner, describing her as mental (this cousin had proposed marriage to her two years ago and had been refused)
c) Her father is having some financial problems and she is receiving less money from him

Items: 26, 27
Intervention: Discussion focused on the first two problems.
Encourage NE to be open about her feelings and future plans and support her
Advise her to be economical in spending money

Evaluation: Patient was coping alright
She decided to refuse her boss's brother's offer
She was open about her feelings towards her cousin, she does not like him but she likes his brother who is married and living in Europe

13th session: 4th week of December
12th interview: NM with NE on telephone
Problems: Nothing new
Items: 26, 27
Intervention: As before
Evaluation: Patient was coping alright

14th session: 2nd week of January
 13th interview: NM with NE at her work
 Problems: Worried about the same problems at work.
 One of her colleagues stole some money (300 E pounds) from the till
 Items: 29
 Intervention: Discussion focused on her feelings and reasons for her worries
 Try to reassure her and accept her worries
 Evaluation: Patient felt relieved after a discussion with her boss about the incident. Her boss reassured her, trusted her more and gave her the responsibility of the till key.
 This approach reassured and pleased NE

15th session: 4th week of January
 14th interview: NM with NE at her work
 Problems: NM worried that NE may regress as her younger sister was getting married
 Items: 27
 Intervention: Discussion focused on NE's feelings regarding this incident and her future plans
 Evaluation: NE was coping alright, happy for her sister and decided to carry on with her job and postpone thinking about getting married herself for two years
 Follow-up phase terminated.

Researcher analysis and impression

Nadia was always comparing herself with her sisters, most of whom were fair skinned, fair haired, university graduates, fluent in French, married and leading successful lives.

Although she was considered very attractive, she did not see that as she has dark hair and eyes, did not achieve any success in high school, speaks French but not fluently, her marriage was another failure and, in addition, some of her family accused her of being mental. She was under great pressure, could not cope with her feelings of inadequacy or being considered as such.

Her family, although highly educated, were far away from understanding her feelings or acknowledging her troubles. Her parents had 7 daughters and many duties to do, so she was left to be brought up by servants who were very fond of her, but had a bad influence on her by teaching her bad language (swear words).

Her mother admitted that she did not give Nadia enough attention and rejected her ever since she was a child. Nadia was struggling hard to gain some attention, to feel equal and to face her family's rejection. She tried to work to escape from the home environment, again because she was not bright enough and had a set way of thinking, she had problems at work.

Most of these problems were resolved when she received acceptance and attention from hospital staff and NM. Her mother and many of her sisters began to accept her and be more welcoming once they understood the pathogenesis of her illness. The return of her father to the family house was very helpful in keeping her family life stable.

The BAI ₃₀ scores on assessment of Nadia's condition

Item No	Section	Statement	BAI Score		
			Admission	Hosp discharge	End of follow-up
7	Communication and social skills	Non-verbal communication	1	1	4
9	"	Accept success/failure	1	3	5
10	Insight	Discuss personal feelings	3	5	5
11	"	Awareness of negative feelings	2	4	5
12	"	Identify source of negative feelings	3	5	5
13	"	Identify source of insecure feelings	3	5	5
14	"	Realistic appraisal of current problems	1	3	4
15	"	Self confidence	1	4	4
16	"	Short/long term achievements	3	4	5
17	"	Sensible in dealing with problems	2	3	5
19	"	Personal hygiene	3	3	5
26	Self and family care	Everyday responsibilities	2	3	5
27	"	Deals with family problems	1	1	4
29	"	Work duties	1	5	5
30	"	Hobbies and activities	1	3	3

APPENDIX 27

BRIEF CASE STUDY

Personal Information (Source: Hospital record)

Patient's name: Abdel El-Fatah
Age: 32 (1984)
Sex: Male
Marital Status: Engaged
Occupation: Assistant Accountant in a large company in Cairo
Diagnosis: Depression
Admission: Acute (1st admission)
Admission date: September 1984
Discharge date: October 1984
Period of follow up: 3 months

Presenting picture (Source: hospital record and patient)

Very depressed, discreet silences, withdrawn, does not mix with his family and stopped going to work. Came for admission as was advised by his psychiatrist.

Family and social history (Source: patient)

Abdel was born and lived in Cairo. His father died when he was only 16 years old, and being financially not well off he had to work at that early age and help his mother to look after his two younger brothers and one sister.

He was also studying to obtain a diploma in commercial sciences. These responsibilities did not give him a chance to mix socially with his mates or pursue outdoor hobbies. He had suffered from poliomyelitis as a child and this had caused some deformity in his left leg causing him to limp. His younger brother and sister were married and now he too is engaged and preparing to get married in three months' time.

Work: Satisfied with his work situation in terms of place of work being near to home and has very good relationships with his colleagues. Unhappy about his relationship with his boss and the insufficient salary.

Religion: Islam

Faith: Believes in God, prays regularly but not very strict observant

Development of the problem (Source: patient)

His problems cover three areas, family, work and engagement.

First, family problems. His mother has a very strong personality, is very dogmatic and much too assertive. This caused him to suppress his feelings. He believed he should remain calm and quiet, obedient and tolerant to avoid confrontations and problems (ie good behaviour). This submissive behaviour did not help him to feel happy or satisfied and it also affected his self confidence and ability to be emotionally independent.

Second, at work he had some problems with his boss. Abdel likes to ensure accuracy in his work, especially with numbers (obsessive feature). He takes a long time in checking the accuracy of his work before handing it in to his boss. His boss spoke to him rudely in the presence of his colleagues. Abdel could not answer him back, felt angry but was unable to express his anger, became very depressed and eventually had to go to the hospital.

Third, Abdel is engaged to his cousin whom he loves very much. This is his second engagement, the first time being four years ago to one of his neighbours. Although he loved her, she rejected him and broke off the engagement because of his lack of assertion and his financial problems. He had begun to worry that this problem might occur again.

BAI₃₀ Assessment

BAI₃₀ scores below 4 were recorded on the following items:

Numbers 2, 8, 9, 10, 11, 14, 15, 16, 17, 27, 29

These items were represented by the following features:

1. Silent most of the time, does not initiate conversation or mix with other people
Lack of assertion and excessive feelings of self blame for any failure

2, 8, 9
2. Finds difficulty in opening up or discussing his feelings
Does not recognise having negative feelings towards his family
Has difficulty in accepting the real cause of his problems
Lack of self confidence
Does not make long term plans
Cannot decide a working resolution of his problems

10, 11, 14, 15, 16, 17
3. Does not deal with his family problems
Has problems with his boss at work

27, 29

Plan of Work

1. Identify the link between the multiple problems of the patient
2. Help the patient to acknowledge and express his negative feelings
3. Encourage the patient to analyse his feelings and to understand their exact cause
4. Teach the patient to be assertive
5. Work out with the patient a plan for resolving his problems
6. Plan for discharge and follow up

Hospital intervention

Mainly chemical, i.e. psychotropic drugs, weekly assessment of his condition during ward rounds
Encourage socialising activities and outings

Researcher intervention

- a) Join ward rounds, discuss his condition and review care plan
- b) Individual psychotherapy, joint session with consultant

Insight, supportive psychotherapy approach was used.
Assertive course in the form of psychodrama sessions
Sessions were on a weekly basis during hospitalisation; each session was a mixture of psychodrama and other individual psychotherapy models.
Community follow-up sessions were every 3 weeks and were held at the patient's family flat.

Intervention Diary

1st session:	Admission, 2nd week of September 1984
Interview:	Hospital Dr with the patient and his psychiatrist
Problems:	Patient is sad, unhappy, silent, withdrawn Has problems at work
Intervention:	Hospital admission No visitor for first week Chemical therapy Regular weekly check up Plan of socialisation and outdoor activities
Evaluation:	Patient accepted hospitalisation, remained withdrawn and silent most of the time
2nd session:	3rd week of September (first contact with AE)
1st interview:	AE with consultant and NM
Problems:	Lack of self confidence, lack of assertion, lack of awareness of negative feelings Bottling up, suppressing feelings Obsessive features Depression and worry about marital status Financial problems and with boss at work

Items:	2, 8, 9, 10, 11, 14, 16, 17, 27, 29
Intervention:	Encourage the patient to talk about his problems Discuss with him in detail his views and concepts about 'good behaviour' Work out with him the plan of therapy Explain to him the purpose of the study and ask for his cooperation
Evaluation:	Patient agreed to cooperate, and to work out the plan of therapy and was more open about his problems
3rd session:	4th week of September 1984
2nd interview:	AE with consultant and NM
Problems:	As before + patient refuses to acknowledge his negative feelings towards his family feelings of hurt and rejection from his ex-fiancee who broke their engagement 4 years ago
Items:	8, 10, 17
Intervention:	Encourage the patient to speak about his feelings of hurt, coping mechanisms and how to cope in the future. Psychodrama about this incident was used. In this the patient was encouraged to discuss his feelings with his ex-fiancee and to defend himself.
Evaluation:	Patient was reluctant at first to participate in psychodrama. The session was very successful and the patient was open about his hurt feelings. Was able to tell his ex-fiancee (the researcher) about his negative and positive feelings
4th session:	1st week of October 1984
3rd interview:	AE with consultant and NM
Problems:	As before + problems with his boss at work
Items:	8, 10, 14, 15
Intervention:	Discussion focused on the incidence of his boss speaking rudely to him, his hurt feelings, what he did, his appraisal of his behaviour and appropriate assertive behaviour in such a situation. Psychodrama dealt with the problem with emphasis on teaching the patient an assertive tone of voice and short explanatory phrases.
Evaluation:	Patient had very soft, low voice, hesitant phrases. With training he became more confident in the way he spoke and more spontaneous.
5th session:	2nd week of October 1984
4th interview:	AE with consultant and NM
Problems:	As before + family problems
Items:	8, 10, 12, 14, 15, 26, 27
Intervention:	Encourage the patient to be open about his feelings towards his mother and younger brother (who is financially better off and who has employed AE in his shop). Psychodrama dealt with his dissatisfaction of the amount of payment he receives from working for his brother.
Evaluation:	Patient was very reluctant to be open about his feelings towards his family, especially his mother. Psychodrama helped him to acknowledge, accept and think of taking action to solve his problem of being underpaid.

6th session: 3rd week of October 1984
 5th interview: AE with consultant and NM
 Problems: As before + preparing for discharge
 Items: As before
 Intervention: Discussion focused on:
 - His plan for resolving his family problems
 - His plan for coping with his work demands
 - His plan for improving his income
 - Arrangements for home visits by NM
 Evaluation: AE was more confident, agreed to the arrangements for home visits and promised to carry out the discussed plans.
 Patient discharged from hospital.

Community follow-up

7th session: 1st week of November (1st home visit)
 6th interview: AE with NM and his mother at the family flat
 Problems: Unable to take decision in his mother's presence, his fiancée refuses to continue with the marriage arrangements (because of his mental illness).
 Items: 8, 9, 27
 Intervention: Explain to the mother the negative consequence of her over-protective behaviour and autocratic decision-making. Encourage AE to voice his thoughts and express his feelings openly regarding his marital problem and the way his mother treats him.
 Evaluation: Mother reluctantly agreed to give AE a chance to breathe and to make his own decisions.
 AE much happier with this new attitude. Decided to discuss his marital problem with his fiancée and her father. He promised not to get apprehensive or depressed about their decision.

8th session: 4th week of November
 7th interview: NM with AE and his mother and younger sister at his family flat
 Problems: As before
 Items: As before
 Intervention: Discussion focused on:
 - The results of his talk with his fiancée and her father
 - His feelings about their decision to discontinue the marital arrangements
 - His family support and reaction towards that incident
 - His future plans
 - His work situation
 Evaluation: His fiancée and her mother were very critical of AE and decided not to go ahead with the marriage. Her father (his uncle) could not persuade his daughter to change her mind. AE was very upset about this decision but was able to cope.
 His mother claimed back all the money and presents given to the fiancée. His mother and sister were very supportive of AE and began to arrange another marriage.
 AE was coping and was content with his work situation.

9th session:	3rd week of December
8th interview:	NM with AE and his mother
Problems:	As before
Items:	As before
Intervention:	Discussion focused on: <ul style="list-style-type: none"> - His coping strategy - His plans for the arranged marriage - His plans for further increase in payment from his brother
Evaluation:	AE was coping well with his feelings of rejection from his cousin. He received back most of the valuable presents he had given her. He was thinking about plans for the arranged marriage but decided not to rush (not to mis-choose again) He was thinking of completing his studies and joining the university part-time to gain a BSc in commercial studies
10th session:	2nd week of January 1985
9th interview:	NM with AE (phone call)
Problems:	As before
Items:	As before + 15
Intervention:	NM phoned AE to ensure he was coping Provided encouragement for his short and long term plans Acknowledged his improved assertion
Evaluation:	Patient was more assertive, more confident of his decisions. Was happier at work, acceptance and welcome had improved his self image. He was thinking of starting an emotional relationship with one of his colleagues who had shown interest in him. He got a rise in salary. His obsessional behaviour decreased.
11th session:	1st week of February
10th interview:	NM with AE and his mother at his family house
Problems:	No urgent problem was identified
Items:	None
Intervention:	Encourage and support AE in his future plans Encourage his mother to continue supporting AE without imposing her own decisions on him
Evaluation:	AE was happier with himself, does not have conflicting negative feelings, became more assertive in general and in particular with his mother. Decided to postpone thoughts of marriage for a few months until he had worked out his feelings towards his colleague and had found out about his prospects of joining the university. Termination of follow up.

Researcher analysis and impression

Abdel had suffered as a child from the problem of poliomyelitis; accordingly his mother became over protective and did not give him a chance to mix socially. Also he had to go to work at an early age (16 years), after his father's death. Abdel was a victim of great conflict between his love for his mother and family and his feelings of lack of assertion and inadequacy imposed by them (even his younger brother would tell him what to do and what not to do).

Psychodrama was very effective in helping AE to acknowledge and express his negative feelings. It was not easy for him to accept them (against his concept of "good behaviour"), however he was very quick to realise the importance of resolving his conflict. He was always afraid of rejection and this caused him to be passive and lacked assertion.

In general Abdel improved amazingly because of his determination to get better, the correct choice of therapy (psycho-drama), and his fortunate circumstances (happy work situation and new, healthy, supportive family attitude).

BAI₃₀ assessment score of Abed El-Fatah's condition

Item No	Section	Statement	BAI Score		
			Admission	Hosp discharge	End of follow-up
2	Communication and social skills	Awareness of negative feelings	1	4	5
8	"	Assertive when necessary	1	3	5
9	"	Accept success and failure	2	3	5
10	Insight	Discuss personal feelings	3	5	5
11	"	Awareness of negative feelings	1	4	5
14	"	Realistic appraisal of current problems	3	5	5
15	"	Self confidence	2	4	5
16	"	Short/long term expectations	3	4	5
17	"	Dealing with problems	1	5	5
27	Self and family care	Family problems	3	4	5
29	"	Work duties	3	5	5